MENTAL HYGIENE

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THE PARTNERSHIP OF PUBLIC AND PRIVATE AGENCIES IN THE FIELD OF MENTAL HYGIENE*

ADLAI E. STEVENSON

Governor of Illinois

I ONCE heard a preacher say that he would travel hundreds of miles, if necessary, to deliver a sermon, but wouldn't walk across the street to hear one. Now it has been my observation—and probably yours, too—that a lot of politicians feel the same way about speeches. So I suppose it was inevitable that I should greet your first annual convention. We're very glad you decided to meet here in Chicago, and I hope that your sessions have been rewarding.

I confess I haven't any profound advice to offer you, which I suppose is an unpardonable admission for any self-respecting politician to make. But I am profoundly interested in what voluntary organizations are doing to find the most intelligent and effective approach to the mental-health problem, which, of course, is a very major concern to any governor.

We are in business together. We are partners in the sense that the care of the mentally ill is a joint enterprise between the agencies. It is recognized more and more that neither can do the job alone and that we cannot get the best results working separately. In terms of responsibility, I consider that your problems are mine, and mine are yours. So we must work together, man and man. I might add that if you ever run out of problems, I'll be glad to lend you all that you need to keep you occupied!

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This is the *first* national meeting after the consolidation that brought your association into existence a little over a year ago, and I want to congratulate you on your progress. Mr. Oren Root, your president, sent me a copy of your first annual report, and I gathered from it that you are not only consolidating all of your old activities and expanding some of them, but undertaking new ones. I was happy to note, too, that you have money in the bank! When I say that the association appears to have made an auspicious beginning, I speak as one highly sensitized to the mercenary aspects of any public or private service—where the money is coming from and how it is being spent. In the best of all possible worlds, I'm sure the word "budget" won't be in the dictionary and then probably insanity won't either!

Probably Mr. Root and all of you who have had a leading part in launching the work of this new association feel like the man falling from a skyscraper, who shouted as he passed the twentieth floor, "So far, so good!" As the first report points out, there is so much to be done by the voluntary organizations in the field of mental health, and the need is so acute for greater public interest in and understanding of this neglected problem, that there is no room for complacency or public indifference to what you are trying to do.

In Illinois, as in many states, there has been tremendous improvement in the standard of care of patients in our mental institutions in recent years. And a large part of the credit for that improvement must go to the private organizations which helped bring the facts of past failures and shortcomings to the people. This aroused public interest has contributed to more adequate appropriations, more adequate personnel, and more adequate methods in mental institutions throughout the country.

Improved hospital care is only one phase of the problem, as you know. We still have a long way to go to create more enlightened attitudes, and to establish broader community participation in efforts to *prevent* mental illness, to identify the symptoms earlier, and to achieve earlier cures. We can't just go on building more and bigger hospitals, because hospital populations have a way of always matching or exceeding hospital capacity. The larger the hospitals, the more people are committed to them. We need better hospital facilities and

more capacity—yes; but we need even more emphasis on early detection and treatment of mental illness. We need to keep more people *out* of mental hospitals.

Here in Illinois more than a third of the employees in state government are working in the services directly related to the support of and the operation of our state hospitals.

About 40 per cent of all the money appropriated for the operation of the departments and agencies under the governor is spent for mental institutions and mental-health services. We have over 46,000 patients in our hospitals now and the patient population has been growing at the rate of 1,500 a year. Even if he tried, a governor, who must be acutely conscious of fiscal realities, could not but be interested in any program that represents such a large proportion of the state tax dollar.

One of the things of which I have been most proud during the last three years is the increase both in the professional and in the non-professional staffs of our mental institutions. Tragically understaffed before, we still cannot get the personnel we need, but we are far better off than we were, with an increase of some 500 men and women on the staffs of our mental hospitals. Even in these days of improved public vigilance about government spending, there has been nothing but commendation for these sorely needed additions to our hospital staffs. And I think this is due in considerable part to the greater understanding, which your organization and others have helped to bring about, of our needs and the long-term economy in better care and treatment of our patients.

In this connection, I think one of the finest things that The National Association for Mental Health is doing is its sponsorship of better training programs for the psychiatric assistants who work in our hospitals. As you know, this association, in coöperation with the American Psychiatric Association, held at the Peoria State Hospital in October the first international workshop on training programs for attendants or psychiatric aides.

At this workshop 32 persons, all leaders in the fields of psychiatry, nursing, and allied professions from the United States and Canada, met to consider the development of more adequate programs for the training of attendants, of whom there are some 80,000 in hospitals in this country alone. When it is

considered that we have over 600,000 hospitalized mentally ill people in the United States, the major part of whose care is in the hands of these attendants, the importance of selection and training becomes obvious. It seems to me that no other single health program offers more possibilities for continued improvement in the standards of hospital care.

But we must do even more than provide humane hospital care. We must apply all of our intelligence and resources toward the *prevention* of serious mental illness—toward early diagnosis and treatment and the return of more patients to their homes and to society. If we do not succeed in this, we shall never be able to build enough hospitals.

These are the areas in which your organization can continue to do valuable work. You can help marshal the various community resources and put them to work. The schools and courts can help by setting up their own psychological or psychiatric units. The churches can assist, too, in establishing community procedures for early discovery and treatment. Local hospitals and clinics can be utilized more fully than they are being utilized.

Business and industry have shown an enlightened and commendable concern for the physical health of their employees. But in only a few instances have they given comparable recognition to their employees' emotional problems. Every community suffers serious financial loss because of the failure in the past to recognize these potential mental problems. Ultimately, the cost is shifted to the state government; when early cases are not detected and treated, the patient usually winds up in a state hospital, where his chances of recovery are reduced because of the long previous delay in proper attention.

The battle against mental illness will eventually be won at home or in the community. That, it seems to me, is the important thing to remember. We can heal more people and do so with greater economy if our skills are improved and our tools sharpened by better understanding of methods of healing. This means slow, laborious public education, and here again you are the leaders upon whom we must rely so heavily.

I am tempted to try to tell you about what we are seeking to do in research—among the aged at our new hospital in Gales-

burg and among very young children at our new training center at Peoria, as well as at Elgin and Manteno. But in the presence of experts like Dr. Menninger and our own Dr. Percival Bailey, Director of the State Psychiatric Institute and research consultant, I had best be discreet.

As I see it, my duty as governor is to see that the men conducting our research work are competent and that they have a free hand and all the resources we can afford to give them. That is our aim and purpose.

While your meeting here is devoted to mental health, I remind you that we in government are confronted with the still broader responsibility for alleviating distress, dependency, delinquency, and disease among all of the people. Until we get to the root of these problems, major reductions in the cost of state government are illusory. For these four horsemen of social disorder are the main causes of the high cost of government, at the state and local levels at least.

In all of these responsibilities, government must look to an informed public opinion to achieve better results. In mental health, as I have said, there can be no successful program of prevention without the efforts of a great many people, those who lead, those who follow, and those who pay the bills. In Illinois we look to the leadership of the Illinois Society for Mental Hygiene and its local affiliates in several counties. I wish we had more of these groups to inform more people about causes, prevention, and early treatment of mental illness. We must develop more local resources for diagnosis and treatment and to dispel the obsolete, defeatist idea that mental illness is a hopeless condition for which cure is rare if not impossible.

Thank God, most mental hospitals can disprove and are disproving this over and over again every day. Within this new climate of thought, and with a new spirit of hope, people who are ill will become better subjects for early cure. When whole communities have this hope, the battle will be partially won and the human race can win a new freedom from an old fear.

AN EXPERIMENT IN PROMOTING HUMAN RELATIONS IN SUPERVISION

PHILIP SCHAFER
Regional Representative, Office of Vocational Rehabilitation, Federal Security Agency, San Francisco
SYDNEY S. NORWICK
Medical Consultant, Office of Vocational Rehabilitation, Federal Security Agency, San Francisco

A NEW approach to the training of supervisors in the civilian vocational-rehabilitation program proved to be so satisfactory that we are reporting it here in some detail. It was in the form of a training conference held at Asilomar, California, July 17–23, 1949, under the auspices of the Office of Vocational Rehabilitation, Federal Security Agency. It included the states of California, Oregon, and Washington. This article describes the objectives, the methods, and the contents of the conference, and finally gives an evaluation of its techniques and results.

The state-federal program is responsible for the vocational rehabilitation of persons with mental or physical disabilities that are substantial vocational handicaps. The vocational-rehabilitation counselor is the case-worker, sometimes called the training agent or rehabilitation officer. Vocational-rehabilitation agencies are authorized by law to provide all the services necessary to help vocationally disabled people improve their capacity for employment. The state agencies, therefore, should have sufficiently skilled personnel to handle adequately the problems and needs of these severely handicapped persons. After a complete medical diagnosis, the agency must be in a position to provide the necessary medical or psychiatric treatment, social case-work, vocational training, placement in employment, or any other service required for rehabilitation into employment.

The primary service of the rehabilitation agency is vocational guidance and counseling. The effectiveness of this function depends upon a total evaluation (medical, personal, social, cultural, psychological, educational, vocational) of the

disabled individual before a plan is made for vocational rehabilitation. The success of the plan is ultimately measured by the individual's adjustment in suitable employment.

Vocational-rehabilitation counselors come to the agency with no standard educational experience or background. Through special training programs and by working on the job, the counselor acquires considerable experience in the use of the special techniques required of him. Because of the many specific skills required, extensive on-the-job training is essential. In-service education must supply the counselor with some understanding of the relationship of his work to social and health programs of other types and to the specific rôle that he is playing in his community. The assistance most vitally needed by the counselor is adequate, day-by-day supervision. Good supervision is indispensable in developing the skill through which total rehabilitation of the client is achieved. Since the quality of his supervision has so important an influence on the effectiveness of the counselor, it follows that the in-service training of supervisors is crucial to the success of the program. With this fact in mind, the conference we are discussing here was arranged specifically for the benefit of supervisors.

The history of the vocational-rehabilitation program can be traced back to the restrictive concept that handicapped people need merely vocational guidance and vocational training. From time to time many desirable features of a total service were added, such as improved techniques of case management, physical-restoration programs, study of guidance techniques, psychometrics, and so on, but with little analysis of the objectives of counseling and often only in response to specific pressures from outside the agency. Insufficient appreciation of the psychological principles involved in dealing with people was recognized as one of the most fundamental weaknesses of the rehabilitation program. In order to develop a sound program of supervision, growth was needed in the following directions:

1. Increased understanding of the basic objectives of the program and of the principles of human behavior, including development of insight into the psychological aspects of illness.

2. Improvement in the use of technical skills related to case-work, to bring about better office management, more adequately organized field work, and the efficient and appropriate recording of case histories.

3. Recognition of the need for more formal training of personnel and the development of a common body of knowledge related to the objectives of the program.

4. Clearer understanding of the functions of specially trained personnel, such as consultants now on agency staffs, psychologists, social workers, physicians, and others.

5. Recognition of the errors inherent in classifying handicapped individuals into categories according to diseases or disabilities, and of the need for planning medical treatment, vocational analysis, or training on a truly individualized basis in order that clients may be assisted to achieve a maximum total adjustment.

6. Avoidance of planning the rehabilitation process *for* the client instead of *with* him, which is bound to occur when the case supervisor makes case decisions instead of discussing case-work concepts and techniques with the counselor and stimulating his thinking.

7. Need for understanding and evaluation of agency functions in order to prevent conflicts with agencies in allied fields of work, such as placement, vocational-training, and social and health agencies.

Various methods of approach were employed. Many types of conference were held, utilizing didactic methods, panel discussions, and round-table seminars, as well as workshop techniques. In-service training sessions were frequent. Agencies were encouraged to develop activities for self-evaluation. Administrative reviews were initiated; consultation was provided in technical aspects of the program; comparative analyses of statistical material were made available. Verbal acceptance of the need for growth and development was often secured, but more often there was a basic misunderstanding which resulted either in failure to translate suggestions and plans into action or in application of the ideas without individual modification. Further teaching of the tools of supervision, techniques of case management, and solutions to administrative problems did not appear justified until the

philosophy of the program was more clearly understood. Such instruction had to be delayed until agencies accepted the concept that the major function of counseling was to act in a constructive way to assist clients.

Evaluation of previous training and techniques suggested that what was needed was not only a fresh, but a more fundamental approach. Were the weaknesses observed in the administration of the rehabilitation program paralleled in other agencies?

The problems observed related to staff development, lack of supervisory skill, and failure to make the best use of consultants. These weaknesses were reflected in a lack of adequate funds and facilities; they were seen in the general absence of suitable machinery for winning community support through interpretation of the needs of the handicapped, and in the quality and scope of the services provided for eligible clients. They were apparent in the lack of proper use and development of those resources and facilities which were available.

In the course of normal operating procedures, numerous opportunities presented themselves for gaining impressions of the quality of other state and community agencies in such fields as health, welfare, public assistance, education, recreation, and public employment. In general, the problems in these other areas were obviously similar to those observed in the civilian program for the handicapped. The approaches used in these other programs, therefore, were investigated to see (1) whether others had been more successful in using the techniques tried in rehabilitation, and (2) whether improved methods were being used elsewhere that would contribute to the efficiency of the rehabilitation program. The field of mental hygiene seemed to hold most promise.

Potential contributions from this direction had been recognized several years earlier when Dr. Kent Zimmerman, Consultant in Mental Health, of the California State Department of Public Health, had participated in a training conference with representatives of state rehabilitation agencies. Analysis was made of a report on an institute held by the Commonwealth Fund in Minnesota.[1] This was a two-week insti-

[1] See *Psychotherapy in General Medicine. Report of An Experimental Postgraduate Course*, by Geddes Smith. New York: The Commonwealth Fund, 1946.

tute during which some general practitioners of medicine had gained an increased awareness of interpersonal relationships and had gone away with a much better understanding of their own emotional problems and the interaction of their own personalities with those of their patients. In 1948, a similar institute was held in California,[1] during which many local public-health officers had also achieved a better understanding of the relationship between their personalities and those of the people they were supervising. Some of them had apparently developed sufficient insight to enable them for the first time to approach with greater understanding the problems of mental hygiene in their communities. Study was made of the techniques used in these institutes and they were discussed with specialists in the field of human relations.

Staff members interested in developing and making use of this kind of approach considered the possibility over a six-months period. Stimulation was occasionally obtained through discussions with leaders in the field of mental hygiene and rehabilitation on national, regional, state, and local levels. Outstanding individuals from the disciplines of psychiatry, social work, and psychology all assisted in crystallizing the project.

After this period of exploration, it was decided to develop a short training session for the purpose of orienting a limited number of supervisory personnel from state agencies in the basic responsibilities of case supervision. It was hoped that a point of view could be developed which could recognize (1) that the supervisor's job is to help the counselor become an effective case-worker; (2) that the supervisor-counselor relationship is interpersonal in nature and is instrumental in assisting the counselor to develop a purposeful and constructive approach with self-discipline as a result of self-understanding; and (3) that the supervisory responsibility requires conscious recognition of self-motivation and continuous self-reëvaluation on the part of the supervisor in order to enable him to initiate and to maintain a positive relationship with the counselor whom he is supervising. Once this point of view could be developed, it was believed that the use of supervisory techniques to guide counselors in meth-

[1] See *Public Health Is People*, by Ethel Ginsburg. New York: The Commonwealth Fund, 1950.

ods of client-motivation (for the purpose of vocational rehabilitation) would become more natural and more efficient.

In order to provide an insulated and informal setting in which students and faculty would be relieved of the traditional, formal conference approach, and in order to escape the demands of their day-to-day work and personal obligations, as well as to insure freedom from any administrative or "supervisory" authority, arrangements were made for the use of a resort hotel. Seven consecutive days of discussion were planned. A conference agenda was worked out originally with the idea that it would be a guide to help the separate sections to maintain relatively the same pace toward the conference objectives.

A small number of supervisory personnel from three state vocational-rehabilitation agencies were to attend. The discussion groups were to be sufficiently small to make possible a sense of identification of the individual with his group, and to permit an opportunity for each individual to participate, and for all to interact upon one another. It was intended that no one subgroup should be "loaded" with inflexible personalities. Supervisors closely in contact in their everyday work were separated. These small groups, among which all the participants were divided, were composed of a faculty member, an assistant faculty member, an observer, and five or six students.

In addition to case supervisors, the group included a small number of administrators and assistant administrators of state agencies. One public-health-trained state-agency medical administrative consultant also participated. Many of the supervisors who participated were carrying small case loads in addition to the administrative and supervisory duties of their jobs.

An advisory committee was informally organized. It was composed of two psychiatrists and a clinical psychologist working in the field of mental hygiene, a supervisor of services from the state staff of a vocational-rehabilitation agency, and two regional staff members who acted as co-chairmen (a social-welfare administrator and an administrative medical consultant). The committee gave considerable thought to the selection of the leaders for the small discussion groups

into which the conference participants were to be organized.

It was hoped to secure group leaders who would be skilled in a dynamic group approach and able to stimulate the desired interaction between the group members. Furthermore, these leaders should, while relating to the day-to-day experiences of the individuals, be capable of using those experiences to bring out the significance of interpersonal relationships between supervisor and counselor, and to begin to unveil the basic motives and feelings of the supervisor that he might have a better understanding of those whom he supervises.

Selected were the psychiatrist who was the mental-hygiene consultant for the Public Health Service regional office, the chief of neuropsychiatric services at a Veterans Administration hospital, and the consultant in psychological services for the Office of Vocational Rehabilitation, Federal Security Agency.[1] These were to be supported by outstanding individuals who could make contributions from other fields. It was anticipated that certain "road blocks" in the form of administrative and management problems would arise to divert the group from discussion of the primary content. Representatives from the social-work field were selected partly to help in the discussion of community organizational, client, and family social problems, but, more importantly, because it was apparent that social work, more than any other discipline, has developed principles and methods for the supervisory job. Because psychological testing is extensively used in job counseling, it was desired that representatives of that field also be represented on the "faculty."

The "supporting" faculty finally was composed of the professor of public administration at a state university, a faculty member from a graduate school of social work, and the psychologist from the regional office of the Public Health Service.[2] The "observers" were the regional medical director of the Children's Bureau, and the psychiatric social-work

[1] Respectively, H. S. Schumacher, M.D., San Francisco, California; Jules M. Wallner, M.D., Palo Alto, California; and Salvatore G. DiMichael, Ph.D., Washington, D. C.

[2] Respectively, George A. Shipman, Ph.D., Seattle; Luna B. Brown, Seattle; and Harold M. Skeels, Ph.D., San Francisco.

consultant of the Office of Vocational Rehabilitation.[1] Participating also would be the two regional staff members of the Office of Vocational Rehabilitation who organized the project.

The faculty and observers met for a short preliminary session the day before the conference was to begin to discuss the objectives, the method of approach, and the exact composition of the small groups. Personal knowledge of the participants of the session aided materially in securing a scattering of rigid personalities, a distribution of persons from the same offices away from one another, and a separation of people who had close administrative relationships. This meeting also provided an opportunity to reassure those for whom this type of conference was a new experience, and to give the leaders of the conference a head start in developing rapport with one another. Several of the group had known little of the operations of the rehabilitation program prior to this introduction, but they were able to adapt themselves rapidly to the problems that were to be discussed.

The conference began in the large, informal lounge of the building in which the whole group was housed. Steps had been taken to provide as relaxed a setting as possible and to develop a feeling of intimacy and identification. All individuals were asked to introduce themselves in such a way as to bring out as much as possible what kind of people they were.

No rigid or inflexible schedule of sessions was imposed in order that the group might feel free from any administrative or supervisory authority. Each group set its own time and place of meetings, but because of the fixed schedule of meals, a pattern developed after the first two discussions somewhat as follows: The group met at 9:00, with a coffee "break" from 10:00 to 10:30, and reconvened until lunch at twelve. The afternoon sessions ran from 4:00 to 6:00, generally followed by an informal conversation in the evening in the lounge and in the rooms of various staff members. Many of the open periods and the coffee sessions were actually

[1] Edith P. Sappington, M.D., San Francisco, and Miss Adaline Johnesse, Washington, D. C.

informal continuations of the organized discussions. An average of not less than five and a half hours a day were spent in discussion.

The first discussion period was introduced by a psychiatrist. He briefly described the insecurities basic to all individuals, and the significant interaction between personalities and the motivations of behavior. The group then divided into separate sections for their own discussions and explorations of the lines of thought started by the discussant. Another psychiatrist began the second day's sessions with a discussion along lines similar to that of the day before, after which the participants again divided into their separate sections. After each of these easy-going, seemingly modulated, but really provocative beginnings, the chain reaction that they had initiated continued without need for additional "firing."

By the end of the second day, the conference director thought it advisable to call the faculty together to evaluate the rate of progress and to discuss whether the various sections were proceeding along lines calculated to achieve the stated objectives. It was concluded at once that, while somewhat different paths were being taken, fairly similar objectives and content were uncovered, so that there was no further need to follow the agenda. It was also agreed that sufficient stimulation for discussion had been given to make further joint sessions unnecessary.

Some of the "students," accustomed to a didactic conference method, felt insecure; others realized that there were outstanding persons on the faculty and wished to benefit from those in other groups; and some were curious about the agenda. Knowing of the faculty meeting, they asked for a "student" meeting. At this meeting, the "students" seemed to divide into two camps. The first and smallest group was composed of those who expressed the need for formal lectures from the faculty. But the majority had already begun to recognize the value of the free exchange and interaction under skilled psychiatrically oriented leadership. The "students" finally evolved a compromise solution which proposed to continue the group-discussion method, but recommended that the faculty teams be rotated as units. In accordance with the policy that the conference be completely

democratic, this proposal was accepted, and each faculty group met in turn with each student group, finally returning to their original sections for the closing sessions.

It must be stressed that the distinction between faculty, observers, and students rapidly broke down in the earliest discussions. Streams of facts and feelings ran back and forth freely (except in the case of a few less verbal participants). No record was made or kept of the subject matter covered in the various group sessions; nor were the participants asked to keep any records or to make reports. As a result, we have a series of impressions, not facts, to report.

With the start of the sessions, the groups discussed "things"—tangible, concrete problems of their jobs, as distinguished from attitudes and their effects upon things. For example, such questions as these were raised: "With inadequate funds, what types of case should we select?" "How is it possible to improve the quality of the job being done if production quotas are imposed on workers?" "What can be done with the counselor who pops in and out the supervisor's office asking for specific information which he already knows or can easily look up?" "Should counselors have specialized case loads?" "How can a counselor take care of his cases if he has so much paper work?"

Then, acting as a psychological catalyst, and providing a psychological climate that met the group at its own level, the leader of the discussion group would raise questions about attitudes, such as, "What attitudes does the client, or the counselor, display that affect his ability to coöperate on a plan of action?" Out of this permissively conducted discussion, centering around attitudes, each section developed a psychological-mindedness which, once started, seemed to increase through the interaction within the group. Once begun, the rest of the sessions were devoted to running down the many avenues in which attitudes affected the supervisory job.

In the beginning, there was a difference in the subjects that happened to be discussed by the various groups. But toward the end, there emerged a similarity in the approach to an understanding of the true nature of the problems, including consideration of the reasons for the reactions of

the personalities involved. It became apparent to the group that people are the same, whether they are clients, counselors, or supervisors. If a favorable setting is provided, if implications of authority are suspended, and if the participants are permitted to express themselves under leaders skilled in drawing out emotional implications and negating prejudices, a process will begin and flow on, constructively influencing the point of view, and perhaps even the lives, of the participants.

One of the supporting faculty, in her efforts to describe the content of the sessions in which she participated said: "Psychologically, the supervisor all too frequently uses the pressure of volume production to allay anxieties about the way the number of successful closures are secured. This anxiety on the part of the supervisor shows up in over-directing the counselor, who may become increasingly dependent on the supervisor, or produces a counselor who works 'day and night.'" Discussion disclosed that the pressure of a production quota was seen as applying to a staff unit rather than to individual counselors. It was recognized that there must be acceptance and understanding on the part of the supervisor that each counselor brings certain strengths to the job and that the supervisor builds on these strengths. One supervisor analyzed the stresses and strains he had experienced in seeking help from two different supervisors, although both maintained the "open-door" policy. The difference between the physical and the psychological accessibility of the supervisor as an important element of interpersonal relationships was explored. The use of approval and disapproval in providing security and status, and the ability of the supervisor to acknowledge an error or to say, "I don't know," were brought out as significant points.

Exploration of the reasons why supervisors have preferred "open-door" conferences to scheduled and planned supervision was painful for some members. The question of the professional ethics as well as the effectiveness of supervisors' "sitting in" on counselor-client interviews as observers of techniques and skill evoked considerable divergence of opinion as well as emotional reactions. There were extensive discussions of the type of training that vocational counselors need and where this can best be secured. This concern about

training grew out of a realization that the rehabilitation of disabled clients was more important than the mere mechanics of getting it done, and that skill in human relations was more than knowing intuitively how to get along with people. Whereas the term, "rapport," had been used to indicate a good relationship between counselor and client or supervisor and counselor, the group began to grasp the significance of interpersonal relationships based on understanding of human behavior and motivating forces.

The supervisor must know and understand the underlying motives that lead people to seek employment in and to remain in the vocational-rehabilitation field. The type of satisfaction counselors find in the job affects the way they work with clients. The often expressed motivation, "I like to work with people," shows up in the undisciplined ways in which some counselors work with clients. One is the all-giving and sympathetic; another withholds and manages and does things for the client. The counselor frequently reacts in his interpersonal relationship with the supervisor in the job done or the quality of his performance. Realistically, the supervisor must assist the counselor in working out a solution, if his services are to be justified. The myriad problems involved in motivating a counselor to improve the quality of his work when he meets only the minimum requirements of the job and has permanent status, came up repeatedly.

The group as a whole came to the realization that generalizations and set answers are impossible and dangerous in therapeutic relationships. This realization created anxiety and was disquieting for supervisors who had come to the institute seeking definite answers to their problems. Although the need to individualize was frequently pointed out by members of the group themselves, they also realized that this type of supervision required more skill than many of them now had, and that realization led to discussions as to how they could improve their knowledge and skill on the job as well as through more formal training.

Similarly, in other sections the problem of production or number of cases also arose. Numerous diatribes were directed against administrators who set numerical standards for "closed rehabilitated" cases, so that the counselors were always working under pressure, attempting to get large

numbers of clients into employment. The group leaders then proceeded to ask why some counselors felt that this pressure was a handicap to good work and why, at the same time, there were so many counselors who were easily able to exceed the minimum standards. The discussion then developed that in many cases the personality of the counselor was more of a factor in making him work under pressure than pressure superimposed from without. Further discussion also revolved about the fact that the number of disabled people awaiting service from the agencies was another factor in the pressure upon counselors, and that this pressure also was a part of the counselor's attitude toward his work and again was not necessarily superimposed upon the counselor by the administrator.

The discussion leaders attempted to turn the questions back to the participants, asking why people act the way they do, thus suggesting that behavior is symptomatic. Some questions that seemed to require definitive answers were related to agency operations, and usually the sensitive group leaders were able to determine when it was necessary to suggest techniques that might facilitate the solution of administrative problems. It was in relation to such problems that the supporting faculty and observers were able to draw constructive contributions out of the discussions.

The group leaders avoided discussions that might arouse too much personal insecurity in an individual participant, and concentrated attention on general situations as related to the supervisory function. Very few of the problems raised in these discussions were completely answered. The process employed throughout was to get the participants to look behind the surface manifestations of a problem and to try to think through their own emotional reaction to the situation presented and thereby attain some perspective on the real meaning of the problem. Many of the problems raised had to do with the philosophy of rehabilitation, the personality and qualification requirements for counselors and supervisors, and the personalities and problems of the disabled. Regardless of the nature of the problems, the group leaders always tried to get the discussions to show that behind many of them may lie personal anxieties of a more involved nature, and

that the solution of many of those relating to case-work in rehabilitation agencies lies in proper supervision.

Little attention was paid to formal definitions of such concepts as "supervision" or "rehabilitation"; rather, the participants were encouraged to talk about their own feelings as to what constitutes supervision and counseling. For the first time, many of them began to see that the problems that came to their desks were often presented as the problems of clients, but in reality reflected the personality and the feeling of inadequacy of the counselor in trying to manage the client. The only supervisory tool that was discussed at any length was the question of the "open-door" policy versus the desirability of regularly structured supervisory conferences.

In regard to supervisor-supervisee conferences, each participant had been asked prior to the conference to write out an interview that he had undertaken with a counselor whom he was supervising. It had been suggested that they might bring these interviews to the conference to use as examples. Not a single participant wanted to use this written interview, although all were encouraged to discuss their problems relating to supervision. Most of them seemed to accept the philosophy behind the use of regularly scheduled supervisor's conferences, recognizing the need for supervising the counselors rather than the cases, and utilizing the conference period to assist the counselor in planning and organizing his work as well as helping him develop his own personality and his own counseling techniques.

One additional technique was utilized to a limited extent as a method of launching discussions. This was the use of recorded interviews of real situations between counselors and clients and between supervisors and counselors.[1] These recordings were very satisfactory for this purpose.

The final session included all the conference participants. They were asked to review the experience with the aim of suggesting improvements in the method. Concerning the initial session, the group agreed that the technique of elab-

[1] These records were contributed by Salvatore G. DiMichael, Ph.D., Consultant in Psychology, Office of Vocational Rehabilitation, Federal Security Agency, Washington, D. C.

orate self-introductions was excellent for the development of a sense of group identity and the encouragement of free discussion. They suggested, however, that the introductions might better have been scattered, since some participants had been awed by the academic background of the "faculty," who had been presented as a group (although neither first nor last). There was also agreement that the terms "faculty" and "student" made no positive contribution and that some designation implying joint participation would be more desirable.

Great concern was expressed by the participants that they had had an experience, difficult to describe, in which their supervisors and state directors had not participated. They suggested that an effort be made to interest top-agency personnel first in any future conference. It was recognized that individuals might not maintain their new feeling about the supervisory function without subsequent stimulation by their own supervisors. In addition to administrator participation, it was felt that it would have been desirable to draw upon a majority of supervisors from one office, to promote "horizontal" stimulation.

There was no feeling that discussion had been shut off too soon on any particular subjects. Usually this was a joint responsibility of the group, and was more or less self-adjusting. While confusing at times, the supporting and opposing points of view were stimulating to serious thought.

A training conference called by an official agency with no attempt to teach specific subjects had been a strange and somewhat disturbing experience. After several days, some of the students developed the realization that they themselves were the subjects of the conference and that definite direction and purpose did exist. By the last day, no participant any longer questioned the project's value.

The group agreed that if there were repeat sessions, they would ask to rotate in order to have the opportunity of meeting the different "faculty." There had been little change in opinion in those who had been for or against rotating initially. Some found it more difficult to adjust quickly to new group leadership; others found assurance that there was one focal point which provided continuity to the institute.

The suggestion was made that it would have been helpful if there could have been some faculty round tables, with students listening, to discuss apparently conflicting points of view among the faculty. Others thought the differences were primarily semantic. The group felt keenly that the faculty teams should not rotate or divide differently. When it was suggested that students be given freedom of choice among the groups, it was pointed out that, even in an institute of this type, it is necessary to have certain limitations. It was generally agreed that there had been an atmosphere which provided the basic setting for the reorientation of thinking.

One supervisor said that he had never before felt free to speak at a large group meeting, but at this conference he did talk about his own feelings in regard to his work, and he felt that he was going to understand much more clearly his responsibilities as a supervisor. Another stated that, as with "St. Paul when he was converted," many concepts suddenly became clear to him as if in a blinding flash of light.

One of the limitations noted was that the briefness of the conference precluded following up on the psychological implications of many possible avenues of discussion. Especially in the early sessions it was noted that while the thought processes seemed to be clarified in one avenue, there was little transference when a new subject for discussion arose. Each individual avenue, as it was opened for discussion, was rather thoroughly explored, yet when new topics were introduced, it was necessary to repeat the whole process and laboriously assist the discussants to talk through the effects of attitudes on the supervisory and administrative problems involved. A longer conference might permit the "students" to develop a pattern for self-exploration that could be more easily applied on returning to the job.

Within the limitations of time and of known techniques, the conference methods utilized were sound. Our experience indicates that the size of the small section or group is of less importance than the types of person who make it up. More of the faculty might well have been outstanding social workers, with teaching and field-supervisory experience.

While the "observers" participated in the discussions and unquestionably contributed materially, they did take the place

of "student" who might have attended. At the same time we realize that, in effect, every one became a student and benefited to some extent.

One question that must be considered in an evaluation of conference techniques is that of efficient use of the time allotted. In the use of this method, the number of hours spent daily in discussion is not as important as what goes on during the discussions. The most difficult problem is to avoid emotional and intellectual fatigue. In this, the schedule used was successful.

The use of recorded interviews as a method of initiating discussions was begun and quickly abandoned. They were found unnecessary for that purpose, and the conference consciously did not want to teach interviewing techniques. Such recordings may be excellent for such instruction, but might better be used in more formal in-service training and staff-development conferences in the agencies or in classrooms.

The two faculty meetings, the one just before the conference and the one after the second conference day, might be eliminated. They probably reflected the insecurity of those administratively responsible for the success of the conference. Certainly little or no special orientation is needed by the kind of faculty used in this type of teaching method, since the basic content of what each has to contribute would apply universally. The second faculty meeting also served no really useful purpose. In fact, it is now clear that instead of yielding to the wishes of the group and rotating the faculty teams, more attention might have been paid to discussion of the motivations back of the request.

It should be noted that a session of this nature cannot be considered a form of psychotherapy for the cure of individual personality problems or emotional blocks. There may be participants who need individualized assistance with their deep personal problems, but these cannot be corrected in a conference, or, while on the job, by supervision.

CONCLUSION

Any values derived from such an institute are, in accordance with its purpose, new, but intangible ideas, changed attitudes, and some insight into interpersonal relationships.

These are concepts difficult to describe, but of great importance to the development of services for the handicapped.

For most of those who participated, there was a realization—or at least a beginning of one—that the essence and objective of rehabilitation are the adjustment and growth of the client as a whole person, rather than his division into parts to be dealt with as such by training, physical restoration, placement, and so on. There was agreement that often the real disability is the inability of the individual to adjust to his physical or mental limitation.

What follow-up there has been in the way of evaluating the influences of the institute on program operation consists of the observations of the agency staff members who organized the institute. Their impression is that definite results are beginning to appear in the state agencies whose directors participated. Since the conference, new relationships have been developed with social, health, and educational agencies for the purpose both of operational and of staff development. The state directors who attended are less defensive about displaying some of their weaknesses and have made plans to provide better supervision to their vocational counselors. It is especially obvious to consultants from other governmental levels that there is much more common understanding of problems—and thus more possibility of mutually satisfactory solutions. Another result observed is the trend toward further decentralization of administrative procedures, since the directors who participated feel much more comfortable about delegating responsibility.

It is more difficult to see and evaluate changes in districts and agencies whose top leadership did not share the experience with their assistant supervisors. It is likely that in these latter cases the desired movement will not occur until, or if, those ultimately responsible for the program allow themselves to be influenced through participation in this type of training institute or in some other manner. Most of the supervisors whose administrators did not participate have made official recommendations that an opportunity for such an experience be provided to all others in their agency. Several directors have indicated that plans will be made to organize such institutes for themselves. This result is especially desirable, since it is likely that much additional value

comes to those who organize such a conference, as well as participate in it.

What occurred in these sessions is difficult to report since the reaction of each participant is an individual effect. It seems clear, however, that predictable and apparent results can be expected from the consciously planned and controlled stimuli provided in the manner described.

It has been found that agencies whose representatives joined in the conference had staff-development problems that could not be solved by the usual techniques. Exploration of the meaning of interpersonal relationships in a dynamic group experience gave promise of a successful device for pulverizing the basic obstacles to good supervision. We recommend the method as applicable to other situations, problems, and agencies.

WHEN DOCTORS DISAGREE

JOHN C. WHITEHORN, M.D.

Psychiatrist-in-Chief, Johns Hopkins Hospital, Baltimore, Maryland

WHEN doctors disagree, what can the layman believe? In the individual case, the layman makes his choice or gets another doctor. It is a disturbing experience. When the disagreement is more generalized, the public is somewhat upset and its confidence in doctors is strained a bit. What can be done about it? In this paper I shall comment particularly upon disagreements on psychiatric matters.

It may be reported, for example, in the press that Dr. X has gathered strong evidence that a certain dread disease occurs in a certain type of person temperamentally disposed by hereditary influence; whereas Dr. Y is reported to have found, in his studies, that the appearance of this disease in many instances has been preceded by a distraught family life in childhood, and Dr. Y, therefore, claims that bad home conditions are the cause. Physicians themselves are not seriously put off balance by hearing, or reading, such conflicting claims. Physicians would be astonished if complete unanimity of opinion were to prevail at all stages in a field of active investigation. An important part of the physician's extensive university education is concerned with the methods of evaluating apparently conflicting evidence. The physician, too, has an intimate and extensive knowledge of special medical fields that often enables him to perceive that observations and inferences that are apparently contradictory may really supplement each other by throwing light on different aspects of a complex medical problem. But the public, not so well trained and not so well informed, have a harder time of it, and their faith in doctors may be shaken.

Recent years have brought a heightened public interest in the special field of emotional disorders and mental disturbances. Certainly, the great public importance of the mental and emotional health of the citizen justifies an avid public interest; the great modern advances in the understanding of

psychiatric problems have provided much material for popular articles. There is a strong temptation, not always successfully resisted, to offer over-simplified popular expositions of psychiatric theory. Some conscientious soul then hastens to correct the errors of over-simplification. Controversial articles thus get beyond the professional journals into more popular publications. A fight is always exciting. Excitement grows, and with it public confusion—and mistrust.

Periods of rapid growth of knowledge, such as the growth in the understanding of human nature that has been occurring in psychiatry during recent decades, are often characterized by sharp differences of opinion.

"Be not the first by whom the new is tried, nor yet the last to lay the old aside," is a bit of oracular advice which is unquestionably wise for many, but just as unquestionably inapplicable to all, else there would be no new to try.

I have recently been asked, "Should not psychiatrists be brought into agreement? Cannot competent authorities determine standards of belief and practice in the field of psychiatry to which all practitioners of psychiatry can be held by professional discipline?"

In considerable measure, scientific meetings and critical professional discussions do operate to reveal and to consolidate a very considerable amount of agreement; but the fundamental means for resolving disagreements about facts or theories is not to be found in conferences, or in committees, or in authoritarian discipline, but in reports of scientific investigation by qualified and conscientious investigators. Those who wish a large measure of agreement—and that includes all of us—have one means, fundamentally, for achieving it, and that is through the support of research in the fields wherein diversity of belief exists. Disagreements diminish and consensus of belief develops as sound knowledge increases.

The basis of agreement must, in the final analysis, be found in scientific research. This takes time, talent, and money. Talent exists; more talent is being developed. Can the time and facilities be provided for research in the problems of mental health, as they have so generously—and so fruitfully—been provided in other fields of medical research? Those doctors and their scientific auxiliaries who are enabled to devote their time and effort to psychiatric research are

the ones who settle disagreements in the only sure way. How slowly, or how rapidly progress is gained will be determined by the measure of support given to psychiatric investigation.

Meanwhile, are there sound means for diminishing the anxiety, distress, and distrust occasioned by present disagreements among psychiatrists?

Much public distress and anxiety can be prevented by the avoidance of public dispute on matters of scientific and professional disagreement. Professional and scientific societies and journals provide the proper forum for the competent comparison and analysis of different professional experiences and scientific hypotheses and experiments. The free interchange of thought and observation within the group qualified to analyse and evaluate sharpens and multiplies the effectiveness of individual workers, but the lay public is not an appropriate jury for scientific disputes.

The public does have a great and growing curiosity about psychiatric questions. The press has developed special workers, who are welcomed at scientific and professional meetings and who exercise special judgment and responsibility in reporting scientific discussions. This is a heavy responsibility. Premature publicity may arouse false expectations, and disappointed expectations may then lead to undue pessimism or distrust, and loss of public support. Sparks from scientific disputes may be fanned into flames in the pages of newspapers or magazines. The press is avid for "personalities." There is a very human desire on the part of the public for the dramatization of achievements by highlighting the individual; and there is enough native exhibitionism in most people—even in members of a profession—to render many susceptible to such temptations. Yet the restraint of individualistic competition for public interest or public favor is a crucial factor in developing and maintaining professional morale. The ideals of the medical profession, as a united profession devoted to the public welfare, are based on a long and noble tradition of subordination of the individual desire for personal glorification. That unity may be disrupted, either mischievously or unintentionally, by exaggerating the importance of an individual. "Personalities" are meat for the press, but poisonous to the integration of the profession. The wise reconciliation of such conflicting

motives and needs requires close collaboration between the representatives of the press and of the profession.

In certain special fields of psychiatry, there are other causes that have operated to exaggerate the appearance of disagreement between psychiatrists. Murder trials and other court cases arouse strong public interest and much newspaper attention. They also not infrequently involve psychiatrists. The so-called "battle of the experts" places psychiatrists in a setting that exaggerates and publicizes every point of disagreement. There is a salutary modern practice of having a specially qualified psychiatric expert serve as the agent of the court, rather than as a partisan witness, whose partisanship is subject to gross exaggeration by the sort of questions that can be framed by the opposing lawyers. Two doctors who have arrived at nearly the same professional evaluation of a person's condition may be asked far-fetched and almost unanswerable questions, to which one will feel obliged to answer "yes" and the other "no," although, in an unfettered expression of their findings, there might be a 90 per cent agreement.

Court "battles" between psychiatrists may be particularly confusing in a trial of the type of person who has not been appropriately responsive to the demands of the community's moral sense, and whose delinquent career demonstrates that regular penal treatment has no helpful influence on his behavior. The psychiatrist who expresses doubt about the "responsibility" of such a delinquent is popularly presumed to be expressing a soft-hearted plea for lenient treatment, whereas he probably has in mind a much more drastic and realistic alternative for the protection of society from such irresponsible persons. Legalistic shibboleths concerning the meaning of "responsibility" may drive an apparent wedge of disagreement between psychiatrists who appear as expert witnesses, although they would actually be found in close agreement if more appropriate concepts and more appropriate institutions were legally available. In Maryland, for example, the legislative and administrative groundwork is now being laid for an impartial diagnostic service to courts and for an indeterminate sentence for criminals of defective personality, with provisions for permanent segregation from

society if necessary, but also for special therapy and possible rehabilitation if the person becomes normally responsive.

When appropriate legal machinery and procedure have been more widely developed to make more constructive use of psychiatrists in legal problems, a much larger measure of agreement between psychiatric experts will be revealed.

The public should know also that statements are made in the name of psychiatry by persons not really qualified.

There is a shameful exploitation of gullible humanity by impostors. A citizen who ordinarily shows good sense and who would make sure to get a qualified veterinarian for his sick dog, may entrust himself and the most significant aspects of his personal destiny to the judgment and influence of a quack, adviser, or "auditor," whose name has been simply selected from the telephone book, or brought to his attention by some advertising device. Why do otherwise sensible people commit such folly? Probably, in the final analysis, the reasons can be traced back to the aura of shame that popular prejudice has traditionally thrown around problems of mental and emotional disturbance. Citizens who have reason to wonder if they may need psychiatric help hesitate to seek guidance and advice by consulting well-informed friends, or even the family doctor, about reliable psychiatrists, because they feel ashamed to do so; and so, instead, they gamble their health on a complete stranger.

What can the medical profession do to enable the citizen to find and to identify a competent psychiatrist? Undoubtedly the wisest course is to subordinate that prejudiced feeling of shame and get the guidance of one's regular physician, who, because of his professional experience and training, will know of trustworthy psychiatrists.

As an aid to the identification of competent psychiatrists, the appropriate medical societies have united in establishing arrangements for the examination and certification of psychiatrists (and of neurologists) by a special board—the American Board of Psychiatry and Neurology—composed of twelve selected directors. There is no legal compulsion to complete this board qualification. It is purely voluntary. The examination is well known to be thorough and comprehensive. A very large proportion of those eligible to do so have, however,

submitted applications and approximately three thousand psychiatrists have met the requirements of this board and received its certificate of competence—often framed and proudly hung on the wall of one's office. All doctors have available to them, either in their own offices or in the nearest medical library, published lists of those so certified. The profession of medicine—and the specialty of psychiatry—breeds some individualists who resist standardization procedures. There are, therefore, some well-trained psychiatrists who have not chosen to seek this indication of competence.

The present requirements of the American Board of Psychiatry and Neurology may be of some interest in this connection, as indicative of the standard of knowledge and experience judged necessary for competence in psychiatry. First, one is required to be a graduate of an approved medical school and to have a general interneship in an approved hospital. This covers a period of from seven to nine years of college, university, and hospital study. In other words, the psychiatrist has first to be a well-trained and somewhat experienced physician, who knows the human body and its modes of functioning in health and disease and the reactions and adjustments of people to the social, economic, and emotional stresses of modern life, as manifested, studied, and treated in a good medical center. In addition, thereafter, one is required to have three years of special, supervised training in the care and treatment of persons suffering from psychiatric illnesses of a considearble range of variety and severity. After two more years of more mature and responsible experience, one can apply for certification. If justified by a review of his career and capabilities by the responsible physicians with whom he had worked, the candidate is admitted to examination, and if successful, he is awarded the certificate. The few thousand so certified are the people who are regarded by the organized medical profession as having established a safe level of competence for the independent practice of psychiatry. Some, of course, carry their specialized training still further, in fields of child psychiatry, forensic psychiatry, psychoanalytic practice, and so on.

The large national organization of psychiatrists is the American Psychiatric Association. It is, as a matter of fact, international, and admits properly qualified members from

any North American country. It is an old and dignified society, which had its beginnings, under a different name, more than a century ago, before the word, American, was so exclusively arrogated by citizens of the United States of America. This association has had a recent vigorous growth, in numbers and in activities. Its membership, now approximately six thousand, has doubled in the last decade. It aims to have a place in its membership for all qualified physicians who are seriously engaged in psychiatric work or training. It is the organization that works to bring all psychiatrists and many auxiliary workers together in an annual meeting for scientific discussion and to thresh out problems of professional standards and goals. Its committees have the exciting and important task of canvassing psychiatric opinion and assembling and formulating data to assist in policy making in the major fields of psychiatric interest that affect professional standards and public welfare.

Affiliated with the American Psychiatric Association are a number of regional, state, or local psychiatric societies. Other psychiatric groups have been organized around interests in special fields, for coöperation with allied scientists, or for the more enthusiastic advancement of special convictions.

One of the more important of the special groups in psychiatry is the American Psychoanalytic Association, composed of those whose practice has been specialized along the lines of the doctrines and technique of Freud. In most European countries and in the rest of the world, the bitterness of the early controversies over Freud has accentuated the sectarian aspect of psychoanalysis and tended to set up barriers and antagonisms that have kept this group of workers a bit to one side of the more broadly trained psychiatrists; but in America the psychoanalytic group have themselves adhered, wisely, to the requirements of medical qualifications and the need for a period of broader psychiatric orientation and experience, and psychoanalysis has, in America, become recognized professionally as a significant part of psychiatry. Indeed, to some of the reading public who have been given partial glimpses of psychiatry only in terms of psychoanalytic theory, psychoanalysis has at times appeared to be the whole of psychiatry!

The field of psychiatry touches upon many aspects of life,

and there are a considerable number of persons, not medically qualified as psychiatrists, who justifiably and ably play auxiliary rôles in the teamwork of psychiatric clinics, hospitals, research institutes, and mental-hygiene services. Clinical psychologists and psychiatric social workers are particularly valued members of the team. A few anthropologists and sociologists are being brought into psychiatric research. Persons specially qualified in the longer-established basic medical sciences—pathologists, physiologists, pharmacologists, biochemists, biophysicists—also participate in psychiatric studies.

All these auxiliary workers have tongues, and many have pens. Some are thereby reporting profoundly significant results of their special inquiries and reflections. Some, inevitably, seek to express their partial grasp of psychiatric knowledge without the discretion and judgment gained only by more complete knowledge, training, and experience.

In summary, then, the public impression of disagreement among psychiatrists has been somewhat exaggerated by the voices of many who have attempted to speak upon psychiatric topics without the necessary qualifications. Some apparent disagreement, especially in court cases, is an artefact, based on the failure, as yet, to integrate legal and medical considerations. Some real disagreements in the field of psychiatry are heightened by publicity pressures, and the public interest in "personalities" and "fights." Much confusion of the public could be avoided, or remedied, by knowing how to find and to identify competent psychiatrists, and to distinguish them from impostors, or from "eager-beaver" apprentices among the auxiliary workers.

Underlying such spot-lighted controversies, there are, actually, some basic disagreements in psychiatric theory and practice, dependent upon unevenness and gaps in the progress of knowledge. The fundamental cure for such disagreements is the support of psychiatric research, whereby the basis of sound knowledge can be extended.

PSYCHODRAMA IN A STATE HOSPITAL

MARGUERITE M. PARRISH

Director, Social Service Department and Director of Psychodrama, Pontiac State Hospital, Pontiac, Michigan

JACK MITCHELL

Case-work Supervisor and Assistant Director of Psychodrama, Pontiac State Hospital

EVERY Wednesday afternoon a group of patients gather in the auditorium of the Pontiac State Hospital. Some of these patients are brought from various closed wards by the nursing staff, while others, who reside in open wards and have ground privileges, come alone. There is an air of friendly informality as they seat themselves in clusters, pairs, or alone. They exchange greetings with one another and with members of the social-service and nursing staff. There is some laughter and gaiety, which subsides when the director asks if the group would like to continue the "family scene from last week." After some discussion and consultation, several people start for the stage. A few chairs are placed about a small table, and the scene of the "X" family at dinner begins. Psychodrama is in session.

Psychodrama was initiated as an experiment in group therapy at the Pontiac State Hospital in June, 1948. The objective of this project was to test the feasibility of psychodrama as group therapy within the limitations necessarily imposed by a state hospital. The goal was, first, to explore the applicability of psychodrama techniques in facilitating adjustment to the hospital by providing outlets for expressions of hostility in a permissive environment; and second, to determine the utility of these expressions for the intellectual and emotional reëducation of patients of various diagnostic categories.

The project was inaugurated by the social-service department after two of its staff members had attended a short course of study with Dr. J. L. Moreno at Beacon House in New York. Prior to this time one of the social workers had observed psychodrama sessions at St. Elizabeths Hospital in Washington, D. C.

The project received the warm support of the medical superintendent, Dr. P. V. Wagley. The assistant superintendent and members of the medical staff participated in the early phases of planning and organization. However, it was felt that the operation of the project should be the responsibility of the social-service department.

The original psychodrama staff consisted of the assistant superintendent, four social workers, and four attendants. The director of the social-service department was also the director of the project. From time to time the composition of the staff changed, but continuity was safeguarded by the director, who was with the project from its inception. The clinical director assisted with the selection of the original group of patients for the project, and has served in a consultative capacity since that time.

The staff met in seminar for a number of meetings to explore the scope and purpose of the project, to review the literature on group therapy,[1] to discuss the processes and techniques of psychodrama and sociodrama, and to organize psychodrama into planning, acting, and evaluation phases. Primary attention was directed to the dynamics of this technique as utilized by Doctor Moreno.[2] Moreover, some of the group dynamics and processes were studied as they became meaningful.

The first group of patients for psychodrama was highly organized in terms of number, sex, and diagnosis—eight women and seven men, ten of whom were schizophrenics and five psychoneurotics. But thereafter the group became amorphous, with less consideration given to these factors. There

[1] The following publications were used and are recommended: *Group Psychotherapy—Theory and Practice*, by J. W. Klapman (New York: Grune and Stratton, 1946); *The Practice of Group Therapy*, edited by S. R. Slavson (New York: International Universities Press, 1947); *Introduction to Group-Analytic Psychotherapy—Studies in the Social Integration of Individuals and Groups*, by S. H. Foulkes (New York: Grune and Stratton, 1949); *Current Therapies of Personality Disorders*, edited by Bernard Glueck (New York: Grune and Stratton, 1946); *Group Therapy—A Symposium*, edited by J. L. Moreno (New York: Beacon House, 1949); and *Psychotherapy*, by Paul Schilder (New York: W. W. Norton, 1938).

[2] See *Psychodramatic Treatment of Psychoses*, by J. L. Moreno. Psychodrama Monographs, No. 15 (New York: Beacon House, 1945). See also, by the same author, *Psychodrama*, Vol. I. (New York: Beacon House, 1946), and *The Theatre of Spontaneity* (New York: Beacon House, 1947).

was no termination of the original group as such. As people were discharged, left on parole or to enter family care, or were unable to participate, others were brought in.

The character of the group thereby changed and the group processes of disorganization, integration, cohesion, homogeneity, and imbalance were repeated several times. The preponderance of certain distinct personality types or diagnostic categories—*i.e.*, psychopaths or too severely anxious schizophrenics—impeded reintegration of the group at times, necessitating conscious effort to offset them. However, it should be pointed out that, in our experience, psychodrama has been helpful to patients who were very withdrawn, hallucinated, delusional, and even deteriorated.

After a period of six months in the group, an attractive twenty-three-year-old girl, diagnosed as hebephrenic, who had lived for five years in a back hall because she was incontinent, denuded herself, and showed no interest at all in her environment, improved markedly in her grooming and appearance and now participates in occupational and recreational therapies. This patient had received therapy from a psychiatrist and had been seen regularly by a psychiatric social worker for over a year without improvement, and had been selected as a candidate for lobotomy.

In the period from June, 1948, to October, 1950, seventy-nine patients participated in this project for varying periods of time. Only eight patients dropped out, at their own request, after attending two sessions. Of the remainder, forty-three (59 per cent) were schizophrenics, with the paranoid type constituting one-half of this number; twelve (16 per cent) were psychoneurotics; four (5 per cent) were manic-depressives; three (4 per cent) were involutional; and four (5 per cent) were primary behavior disorders. The rest of the group consisted of psychopaths—an epileptic, an alcoholic, and three with organic syndromes. The group consisted of twenty-nine men and forty-two women; two-thirds of them were under thirty-five years of age and had had more than eight years of schooling.

The patients who attended were also active in other therapies prior to, concurrent with, or subsequent to psychodrama. These therapies included individual intensive psychotherapy with a psychiatrist; interview therapy with a social worker

or a psychologist; occupational therapy; recreational therapy; music therapy; and convulsive (electro-shock and drug) therapies. However, one-third of these patients had only psychodrama and recreational or occupational therapy. Psychodrama often was the bridge leading to other therapies or, temporarily, out of individual psychotherapy when it was discovered that the patient was unable to handle the intensity of transference or could not relate too easily.

The actual operation of psychodrama consists of three phases: planning, acting or dramatic presentations, and evaluation. In the morning, before the actual group meeting, the psychodrama staff meets in the office of the director to plan the session of that afternoon. The staff discusses the status of each patient in terms of his illness and his adjustment to his illness, to the hospital, to his family, and to the psychodrama group. The behavior of the patient in his present and immediate environment is the primary focus, although the staff makes use of the case history and records of the patient's progress in psychodrama for diagnostic evaluation and as a guidepost in the treatment process. Within this framework, the patient's needs are analyzed and scenes are devised and cast, with staff members or patients as auxiliary egos or dramatic aids.

Initially, scenes were planned on a causal and symptomatic basis, and these scenes directly related to situations and individuals involved in the patient's illness. Although there was some participation by the patients, nevertheless, the anxiety evoked in the individual patient and in the group, and the infrequency of our sessions, necessitated modification of this procedure. Derivative or secondary situations were utilized and modified further to the planning of imaginary or "like-reality" scenes. These generalized or universalized scenes enlisted more spontaneous participation by the patients since they provided the security of anonymity and permitted the patients to bring to them whatever feelings or attitudes they wished, and in the amount and nature that they felt able to handle without too much fear, guilt, or shame. In this way the patients were helped to achieve a level that enabled them to present scenes immediately involved in their own problems with less anxiety.

Scenes usually center about situations of conflict over the

meaning of mental illness; over commitment and stay in the hospital; over hospital figures of authority; and over family, marital, and other interpersonal relationships in a time sequence from the past to the future. In as much as problems in interpersonal relationships are generally problems of psychotics, scenes planned for individual patients in most instances carry over to the remainder of the group.

The casting of scenes is inextricably related to and involved with the creation of situations. Care must be exercised in the selection of personnel, not only to allow for the proper expression and satisfaction of the patient's needs, but also to provide the proper therapeutic atmosphere and direction for the successful enactment of these devised scenes. Scenes are "taken over" or "fall flat" if improperly cast. It is worth repeating that casting is done in order to permit patients to express freely their hostility or their dependency, or to exhibit defenses in these planned scenes. An additional and important factor in our setting is the consideration of group interest and attention. Often this necessitates emphasis by the director that *what* is acted rather than *how* it is acted is the primary concern.

We have found that the scene is more meaningful to the individual and to the group when it is spontaneously performed. To be sure, the patient is not an actor, but free and uninhibited acting is not only valuable in releasing the patient's feelings, but also helps and stimulates other patients to objectify and crystallize their own feelings, which in turn serve as the basis for discussion and interpretation. In this manner a twofold purpose is realized—ventilation and interpretation. Within a group setting this allows for emotional and intellectual reëducation and reorientation of the individual as well as of the group to appropriate modes of social feelings and behavior.

While it is the primary responsibility of the psychodrama staff to devise situations and to cast scenes, nevertheless, our experience has been that individual patients or even the group periodically and spontaneously request scenes and cast them themselves. This has stimulated patients to write out scripts and to serve as directors themselves.

The case of Betty, a teen-age girl who was extremely withdrawn, hallucinated, and infantile, is relevant. More hebe-

phrenic than catatonic, though diagnosed the latter, she was referred to psychodrama after other therapies had been tried unsuccessfully. A family-care placement had been recommended, but Betty refused to consider it. She was brought to psychodrama, but did not participate. She slumped in her seat and kept her head bowed, occasionally giggling in an unmotivated manner and whispering to herself.

Staff members made it a point to talk to her and to sit next to her. After several months, she began to show interest in the stage action. On one occasion she beckoned to the director and asked about family care—could it be acted for her? In the ensuing eight weeks, scenes, most of which were planned and cast by the patient, were enacted for her. The scenes portrayed Betty's mythical family-care home, which was on a lake and in which Betty had a puppy dog. Through the help of staff members and other patients, she was able to go on the stage herself to meet her "family-care" family, to talk with them about how she would live, about her own ideas and plans, and so on. Subsequently, Betty was placed in a family-care home that was similar to her imagined one and in which she has lived thus far for over nine months. The participation of the patient group in these scenes was particularly outstanding and provided a richly supporting, assuring, and gratifying experience not only to Betty, but to the group as a whole.

One must, however, be aware of a patient's use of his own material as possible resistance and defense, although on the whole we found that it serves to make the group cohesive and active.

The acting or dramatic-presentation phase occurs in the afternoon when the group convenes in the hospital auditorium. The director of psychodrama describes the scene or situation briefly and selects the participants. There is usually a short consultation with the director by the patient-actors and auxiliary egos for further clarification of rôles. The actors then go onto the stage and spontaneously act out their rôles. A stenographer takes verbatim notes of the dialogue in the various scenes.

The degree of spontaneity varies from person to person, from scene to scene. There is movement in and out of rôles

by the patients, although the auxiliary egos attempt to maintain the integrity of the scenes and of their rôles. However, the staff is alert to the expressions of the patient-actors, and when the latter are producing meaningful material, even if it is tangential to the devised situation or rôle, the auxiliary egos follow the patient, stimulating and encouraging his trend.

For example, the staff had devised an employment-office scene in response to a request from a patient whose discharge from the hospital was near. This patient was a young adolescent girl, diagnosed primary behavior disorder, who had a background of truancy and maladjustment and had often threatened and several times attempted suicide. After she had participated in the scene with seriousness and eagerness, a new patient spontaneously moved onto the stage and asked for an "odd job like selling refrigerators to the Eskimos." His participation was unexpected and his intent was apparent. It provoked general merriment in the audience. However, the auxiliary ego, serving as the employment manager, followed the lead of the patient, but maintained his own rôle. The scene was permitted in order to satisfy the testing-out need of the new patient. This acceptance by the auxiliary ego as well as by the audience helped the patient to greater participation, and in subsequent sessions, he acted scenes approximating his own conflict with his wife.

In another employment scene, in which a patient acted as the employment manager, a woman patient in her early thirties, diagnosed as schizophrenic, paranoid type, mounted the stage and stated that she could get a job. She was delusional and would not sit down because of the "electricity in the seats." She was also extremely hallucinated and talked to voices as she stared toward the windows. She had been a hospital-management problem, insisting that she did not belong in the hospital. During this scene she refused to sit down, and the patient employment manager asked why. To her reply that there was "something wrong with the chair," he responded, "That's funny. Other people sit in it without fear." He then asked what kind of job she wanted. She became agitated, rubbed her head, and moved about restlessly. Despite reassurance from him, she broke down exclaiming: "I never had trouble like this before. I guess I couldn't get

a job. I must be sick and should be here." Thereafter, she stopped requesting to be released and began to adjust in the hospital.

Resistance to acting varies from patient to patient, but rarely does a patient refuse to go on stage. Particular care is taken, however, to protect the inhibited patient from a sense of failure or from attack by surrounding him with auxiliary egos—staff members or patients—who carry him along by their leadership and activity. Some preparation is done by the auxiliary ego who sits with the patient prior to the particular scene and goes on stage with him. Moreover, the withdrawn patients are helped and encouraged to go on the stage in group scenes in which they can be made to feel secure. The smallest degree of participation is praised warmly.

It is of extreme importance to be aware of active patients who direct hostility against other patients who are unprepared for these displaced feelings. It is interesting that aside from the immediate response of the director, who alerts auxiliary egos to the defense of the attacked patient, older patients respond quickly to exert pressure from the audience against the punitive patient-actor and to express support for the "victim." This often generates a good deal of discussion and ventilation of feeling.

The group responds in much the same fashion whenever patient-actors use obscene language or make sexual references and suggestively exhibit themselves. Mary is a case in point. She is a thirty-six-year-old woman, married, but legally separated from her husband, and the mother of a young girl. She is diagnosed manic-depressive psychosis, and has been hospitalized almost continuously since 1939. Prior to her attendance in psychodrama, she was in a disturbed ward because of her constant difficulty with hospital authority and her long record of truancy, and was denied permission to attend occupational and recreational therapy.

Very quickly after she joined the psychodrama group, Mary injected herself into every scene and dominated it by using profanity, acting as a prostitute, and so on. When the group protested her actions on the stage, she became critical and hostile, and dominated discussions in the audience. The group then openly expressed their displeasure and criticized her

sharply. As Mary began to respond to this group pressure, the psychodrama staff limited her to one scene which she might develop in her own way—a "Mary scene"—and devised situations in which she was placed in rôles of responsibility and in which her behavior would have to be socially acceptable and appropriate. In the last three months she has been able to share her own scenes and intrude less frequently into other patients' scenes. Her hospital adjustment has improved. She now attends both occupational and recreational therapy and has also begun to have weekly interviews with a psychiatrist.

The acting phase of psychodrama reveals the individual as well as the group in action. Participation is not only on the stage, but in the audience as well. Periodically "man-on-the-street" or "polling" scenes are devised in order to enlarge the stage to encompass the entire auditorium, and there is a constant flow of communication and participation between the stage and the audience. In addition to this interplay during the scene, the group often is stimulated to a discussion of the nature of the problem being presented. The imaginary or "like-reality" scene promotes expressions of and elaborations on such themes as "That's how my parents are," or, "No wonder people get sick when they are treated like that!" or, "That was just like my husband," and so on. It is in these discussions that the group attention is focused on exploring the dynamics of particular feelings and appropriate modes of the behavior indicated. A discussion is most successful when it leads into spontaneous scenes on the stage on how parents or married couples or children should feel and behave.

In the evaluation phase, which follows the termination of the acting session and the return of the patients to their halls, the psychodrama staff discusses the result of the planning and the acting phase. The discussion is informal, but analytical. An over-all impression of the session is arrived at: it was stimulating; too much discussion, not enough acting; too much acting and not enough discussion; very slow and flat, or high; too much talking in scenes and little movement; splendid general participation; and so on.

The discussion invariably moves into the areas of individual response and participation in scenes, group response

to the individual actor and the scene, and the discussion that follows. A close analysis is made of the movement, if any, of the patient in his planned scene and in the rôle. Was it therapeutic? Where? How? Why? Where do we go from here? If the scene failed to meet the goal for the patient, what did he express in the scene? The group is discussed in terms of participation, interest, interrelatedness, structure, and discussion. The director, who always places herself in strategic locations during sessions, reports her observations of patient reaction in the audience to the scenes, the patient-actors, and the others in the audience. The rôles of patients in the group are evaluated and explored. Attention is then directed to the increasing isolation and withdrawal of some patients and the grouping or clustering of others. Finally, the strategy for the next session is suggested to the staff for individual thought and consideration.

Our findings regarding psychodrama as a group therapy are in substantial agreement with the results obtained not only by psychodramatists, but by practitioners of other forms of group therapy.[1] In our experience with a variety of patients from the most deteriorated to those in relatively good contact, we have obtained results with these patients leading to improved hospital adjustment in most, the development of insight in many, and significant personality changes in a few. Of the original seventy-one patients, forty-five are now out of the hospital on discharge, parole, work parole, and family care. Twenty-six patients remain in the hospital, of whom sixteen indicate better ward adjustment and greater use of hospital therapies and facilities than before the experience. Only ten patients show little or no evidence of improvement.

We have ascertained that psychodrama specifically assists

[1] See publications previously mentioned in the notes on page 34. See also *Drama Therapy at Winter Veterans Administration Hospital*, by V. W. Bikales (Report read at the Joint Meeting of the Missouri-Kansas Psychiatric Societies, Kansas City, Missouri, March 27, 1949); "The Use of Group Therapy in Psychoses," by James Mann and Elvin V. Semrad (*Journal of Social Casework*, Vol. 29, pp. 176–81, May, 1948); "Group Treatment of the Mentally Ill," by J. W. Klapman (*Survey Midmonthly*, Vol. 82, pp. 80–81, March 1946); and the discussion by Nathan W. Ackerman of the psychiatric viewpoint in group therapy in "Group Therapy," a report of a special section meeting in the *American Journal of Orthopsychiatry*, Vol. 13, pp. 678–87, October, 1943.

the individual patient to reëstablish interpersonal relationships; to abreact traumatic situations and diminish anxiety; to test and explore reality, as well as to build and strengthen his ego; to develop emotional awareness; and to practice or experiment with his acquired gains and knowledge in numerous problem or conflict situations and with a friendly, supportive group of patients and trained staff. Furthermore, psychodrama has been very useful in helping and preparing patients for individual psychotherapy and other therapies in the hospital.

It is worth emphasizing that spontaneous acting-out often produces meaningful material from patients who manifest incapacities for verbal communication. In addition, acting objectifies and crystallizes a problem in another dimension—a visual-auditory presentation—which is lacking in other therapeutic techniques, except in part in play therapy with children. We are impressed with the ego-strengthening or ego-building implicit in overcoming and testing problems in imaginary or "like-reality" scenes; the catharsis that follows from an enactment of rôles that meet deep emotional needs; and the development of emotional awareness and insight in this process.

We found that weekly sessions were insufficient, as they handicapped and prolonged the treatment process because of the difficulty of sustaining and carrying-over the individual gains from one session to the next—a week later. Changes in staff personnel and in the patient group were added complications. An increase to three sessions weekly would do much to overcome these difficulties.

Our experience, we feel, not only justifies an affirmative answer to the questions as to the feasibility, applicability, and utility of psychodrama in our hospital, but warrants its greater study and use in state hospital and clinic settings.

PSYCHIATRIC CASE STUDIES WITH TEACHERS

MARK KANZER, M.D.

New York City

FAMILIARIZING teachers with the principles and applications of modern psychology is one of the foremost tasks of preventive psychiatry to-day. Any general outline of psychodynamics in terms of libidinal phases of development, Œdipal constellations, or transference phenomena underlying learning and behavior problems, is likely to leave the average teacher sceptical and perplexed as to the application of these concepts in the classroom; nor can the permissive attitude and cultivated anonymity of the therapist be duplicated in the school. If psychiatry is to make its contribution to modern education, it cannot be through converting the teacher into an auxiliary or substitute psychiatrist; the practical problems of managing groups of children and directing them toward educational, not therapeutic, goals, must remain both the basis and the limitation of the rôle that we ask the teacher to assume.

Within such a framework, we may deepen the teacher's understanding of the child's mind and strengthen the trends that have long appeared in education toward placing stress on personality development rather than on the accumulation of knowledge, and toward adapting the curriculum and methods of instruction to this end. Along with such progressive changes, there have necessarily developed new concepts of the qualities and attitudes that best fit the teacher to play her part in making the school the effective agency it can be in relation to the maturing youth and the community.

The psychiatrist who would be helpful in achieving such desirable reorientations is not sufficiently equipped for this purpose if he is able to place before the educator merely his own clinically oriented perspectives on behavior and motivations; for his part, he should be familiar with and prepared to contribute to the solution of problems of pedagogy. Under-

standably, few psychiatrists, even among those who have specialized in work among children, possess the requisite classroom experience or the knowledge of how to deal with students in terms of educational rather than therapeutic goals.

Nevertheless, it may happen in some communities that the schools will wish to make the viewpoint of the psychiatrist available to the teaching staff. The potentialities in this direction may be indicated by a description of such an in-service course which was arranged despite the confessed shortcomings of the psychiatric instructor in the educational field. The psychiatrist does not willingly let pass such an opportunity to contribute to the forces that make for progress in the mental hygiene of the community. Moreover, there is much for him to learn, as well as to impart, in contacts with the educators of children.

In the instance to be described, there was an enrollment in the class of thirty-two elementary and high-school teachers, principals, and guidance personnel. About one-third of the group were quite well informed about and convinced advocates of modern psychological trends in education; others had registered for a variety of reasons, including the desire to obtain credits. There were some misgivings over the resultant heterogeneity of the class, but administrative policy permitted no choice. From the psychiatrist's standpoint, moreover, the opportunity to introduce elements of mental hygiene to the less experienced participants seemed of considerable importance.

In view of the composition of the group, the decision was reached to develop the program along two lines: first, to proceed essentially on a basis of case presentations by the teachers, which would make it possible for each participant to glean or to contribute according to his or her capacity; and secondly, to encourage the teachers to take as the basis of their work the actual current problems that arose in their own classrooms. From the discussion of individual cases, it was planned to develop more general perspectives.

For this reason, the participants in the course were advised, at the first session, to select from among their pupils some candidate for observation and study during the semester. (There were to be fifteen two-hour meetings weekly during

this period.) Lists of reference material were distributed,[1] and the remainder of the session was given over to discussion of such standard procedures as the use of anecdotal records, sociograms, compositions, drawing, and play, in gathering information about children. Direct interviews with pupils and their parents, consultative exchanges at teachers' conferences, and recourse to cumulative school records were also touched upon in relation to the proposed project.

The choice of problems was left to each person to determine. There was, however, some review of the types likely to be selected; for example, mention was made of the well-known predilection of teachers to show more concern over aggressive than over shy children.[2] A special point was made of the fact that members of the group were not expected—in fact, were advised against—devoting more time to the study of a "case" than was ordinarily expended on a difficult pupil. Further, it was indicated that the development of the course would presumably result in the first half's being devoted to gathering material and gaining insight into the children's problems, while the second half would stress remedial measures and general management of the classroom. This structuralization was designed to discourage the tendency to present the instructor with "practical," but poorly conceived questions that had not been placed in the proper dynamic contexts. For example, one teacher told of a girl in her class with a reputation for stealing and asked for suggestions as to how to trap her.

As had been anticipated, the proposed outline of the course was received with considerable doubt by the group. Many

[1] This material included: *Play Therapy*, by Virginia Axline (Boston: Houghton Mifflin Company, 1947); *Mental Hygiene in School Practice*, by Norman Fenton (Stanford University: Stanford University Press, 1949); *Fostering Mental Health in Our Schools* (Washington, D. C.: National Educational Association, 1950); *Psychoanalysis for Teachers and Parents*, by Anna Freud (New York: Emerson Books, 1947); *How to Help Your Child in School*, by Mary and Lawrence K. Frank (New York: Viking Press, 1950); *Emotional Disorders of Children*, by Gerald Pearson (New York: W. W. Norton and Company, 1949); *Discovering Ourselves*, by Edward Strecker and Kenneth Appel (New York: Macmillan Company, 1943); and *Understanding the Child*, published quarterly by The National Association for Mental Health, New York.

[2] See "Personality of the Teacher," by Percival Symonds (*Journal of Educational Research*, Vol. 40, pp. 652–61, May, 1947) and *Children's Behavior and Teachers' Attitudes*, by Edward J. Wickman (New York: The Commonwealth Fund, 1928).

had apparently expected a series of "question-and-answer" sessions, in accordance with some popular conceptions of psychologists as omniscient beings who have ready answers to all problems. Others had looked forward to effortless participation in lectures on "deeper" dynamics—*i.e.*, sex. Relatively few seemed to regard an active personal study of their own pupils as the proper approach to classroom problems.

Analogies to typical situations that arise during early phases of individual therapy readily suggest themselves. The participants had little belief in or desire for the development of their own resources; dependence on the psychiatrist's "magic" was evident. Realistic difficulties that would interfere with the proposed program were adduced and exaggerated so as to cover less readily explained misgivings. Several teachers came forward to plead that at present, in contrast to all their previous experience, their classes were filled with well-adjusted children who presented no problem at all; others brought up the inevitable claim of being overburdened with other duties. Doubtless one should not overlook the unspoken, and not always unjustified, fear that the demonstration of difficulties with pupils might be interpreted by colleagues as evidence of inefficiency. Nevertheless, in the opinion of the instructor, if the course were not to evolve into an intellectual exercise isolated from actuality, some means would have to be found to confront and resolve these problems.

As in similar situations that often arise in therapy, there seemed, therefore, to be a need for the instructor to assume an active rôle in developing his relationship with the audience. For this purpose, he devoted the second session to a presentation of his own case material, despite its inevitable clinical slant. Typical classroom aspects were set forth, such as aggression, shyness, delinquency, and learning difficulties at various age levels. The teachers were then conducted "behind the scenes" as these children were brought to a child-guidance clinic and subjected, with their parents, to the processes of social-service intake, psychiatric interviews, and appropriate forms of therapy. The operation of the influences that dispose to the development of and the relief of such disorders was outlined, with special reference to types of teacher-pupil relationship. For example, the spon-

taneous acting-out in play therapy of the child's interpretation of discipline was delineated, and also the means that some teachers had found for coöperating with the psychiatrist by the recognition of special abilities in an insecure student.

The third session was taken up with a more detailed study of typical character and behavior patterns, with emphasis on (1) the rôle of early oral and anal experiences in molding the relationship between parent and child; (2) the meaning of maturation; (3) the origin of symptoms and behavior disorders and their prevalence in the classroom and community; (4) the determinants of the child's readiness or unreadiness for adjustment to school routines; and (5) corresponding problems in the classroom needs and management of the individual pupil.

These two lectures, of course, were designed to do more than provide information for the group; they served to indicate the viewpoint and scope of the proposed studies. Such guidance by the instructor seemed necessary to create the framework within which the teachers could work most comfortably and productively. If a directive element was present, then this must be regarded as itself a concomitant of educational rather than therapeutic goals. Perhaps, too, it may be correct to suppose that the instructor, if successful in his assumptions, was verbalizing for the group the motives and aims of the course—at least in so far as the more advanced teachers were concerned.

Perhaps the result of this directive approach was to be found in the paucity of comments from the audience during these three sessions. What prevented discouragement, however, corresponding to free association as a means of keeping in touch with the thoughts and feelings of the group during this period, were the contacts with members in the generous intervals allowed at the beginning and end of each lecture for seeking out the instructor for questions and discussion. During these periods very lively interest was displayed and audience reactions could be better gauged for purposes of shaping subsequent sessions.

Especially in the beginning, it was clear that the problems that the teachers brought up outside the formal lecture hours were largely personal in nature. The instructor, however, politely, but firmly refrained from becoming involved along

these lines and countered instead with questions about problem pupils and interrogations as to topics that might be taken up during the course. Discussions were often diverted into useful channels in this way.

The lecture on character formation, however, elicited a particularly vigorous response, still mostly through the "Greek chorus" at the beginning and the end of each session, but also to some extent during the lecture hours. To the instructor's surprise, two themes were brought forward repeatedly from within the audience and were obviously productive of perplexity and anxiety: (1) the statements of the instructor seemed to feature too much the importance and shortcomings of the mother, as compared with the father, in influencing the development of the child; and (2) since character seemed to be determined to so great an extent by the experiences of the earlier years, what scope was there for the teacher's efforts and what became of the time-honored concept that schools breed character?

Both questions could readily be interpreted in terms of an individual analysis of this predominantly feminine audience; both were continuations of the resistance which implied that there was little they could be expected to contribute to the problems under discussion. This development was, of course, an indication for introducing the disturbing topics openly into the fourth session, with some exposition by the instructor, but with care to permit the interest and feeling of the group to take over as actively as possible the ensuing debate. This maneuver did in fact prove quite successful; instances were cited by the teachers in support of their varying views, and the instructor endeavored, wherever possible, to link the discussion with specific and common classroom problems.

At the end of this session, many definite questions were asked at the "private audience" relative to actual problem children that the teachers proposed to study. It was quite apparent that each participant was voicing her own concern and seeking reassurance about proceeding with her spontaneous methods of pedagogic psychology. In most instances, such anxieties could be allayed by permissiveness; sometimes, as with the teacher who wished to trap the little girl who stole, special orientation could be provided.

The beginning of the fifth session brought definite confirmation of the fact that a turning point had been reached and that the impetus for further developments would come from within the group itself. A very interesting case study was submitted by Mr. X, bearing the imprint of his advanced and experienced methods. The child selected as a problem was Harry, an eight-year-old boy who had functioned consistently below his high intellectual level and whose behavior, while not outstandingly disturbing, was calculated to arouse the attention of the thoughtful and psychologically penetrating observer. Mr. X described his persistent efforts to win the confidence and to learn and utilize the spontaneous interests of Harry; he had been quite unsuccessful in achieving his aims and requested the opinion of the psychiatrist.

Possibly a hypothetical sketch of the dynamics of the situation at this point would not have been amiss, even though difficult to confirm. To the instructor, at least, it seemed as if his own positive stand on various points had set him up as a figure with whom X found it easy to identify, and that in the sketch of X's efforts to find a point of contact with his pupil, there was a reflection of the instructor's own difficulties in initiating rapport with the group. At any rate, X's presentation did set off a process within the audience that was unmistakably analogous to the working-through of a resistance during individual therapy. His discussion of Harry at once aroused, like a repressive force, the objection from Mr. Y that too much time had been wasted on the child and that the application of a hair brush would have been more properly indicated.

Throughout the remainder of the course, the intra-group conflicts over psychology in education found expression in such duels between X and Y. Doubtless deeper implications could be seen in the rivalry of these two aggressive men for the sympathies of the predominantly feminine audience. In any event, interest was heightened and the clarification of group thinking was unmistakably served by these developments. The instructor, too, was able to assume to a greater extent the rôle of impartial observer who could promote the spontaneous movements within the audience instead of acting directively.

In this first exchange between X and Y over Harry, the

group itself shaped the proceedings by sweeping aside the suggestion of recourse to the hair-brush technique and, in fact, exposed the inadequacy of X's approach by demanding information about Harry's family background. Now X, in turn, was forced to face one of his own limitations. At first he admitted that he had withheld important details for reasons of "discretion," but it became apparent even to him that more personal elements were involved.

Harry's domineering mother had resolutely refused to consider any possibility that the home situation (and her personality) had contributed to the child's difficulties, and had countered instead with incessant demands that the school invent new expedients for coping with the problems presented by her son. It was evident that X had been worsted in his interviews with the mother and that in a sense Y had been correct in maintaining that too much had been done. X spontaneously promised a more resolute approach to the parents; from the standpoint of the developments in the group, a very decisive step had been taken in formulating the principles and practices for management of a common and important classroom problem.

Further events in the history of Harry, as they were reported during the semester, showed the possibilities for the development of a "continuous case study" among the teachers. X, emboldened in his position by group support, enlisted the aid of a school psychologist whose tests confirmed conclusively the supposition that the boy's underlying disturbance was deep-seated and severe. Then X established contact with the father—the mother seemed inaccessible, or was, perhaps, too challenging—and secured the promise of assistance from him. Although no consequences were immediately apparent, the value of the study and of the measures already taken was shown a little later when Harry was involved in "delinquency" through accidentally hitting the car of a passing motorist with a stone which he had flung at another boy. The disposition to see such an affair in a purely disciplinary light—a viewpoint that still found a proponent in Y—had been effectively counteracted by the preliminary psychological investigation, which had demonstrated impressively to most of the group the need for prophylactic and remedial measures in problem cases.

By such means, it was possible to make constant advances in terms of actual material brought forward by the group. In the case of Ray, aged six, the question of whether to permit the mother of an anxious child to stay in class until the fears of the first school days had subsided, became merged into a wider view of the problems that arise when a middle-aged couple, oversolicitous about an adopted son, do not give him the opportunity to develop his own resources or make the acquaintance of children and adults outside the family circle. From this point, it was natural to proceed to the dynamic factors involved in handling Ray's unreadiness to read and his excessive demands for the teacher's attention.

Phyllis, the girl who stole, was found to come from a broken home in which the parents had been constantly dishonest with each other and with her. The significance and variety of manifestations of sex conflicts in this child, as well as in others with analogous symptoms and behavior disorders, were discussed.

Accident-proneness as a common and important factor behind a host of puzzling difficulties also received consideration. In the case of Bob, aged ten, who was always becoming involved in catastrophes, this tendency was found to be related to the death of his mother four years before. Bob's compositions proved very illuminating to the teachers:

"My Life

"When I was about three years old we moved to a different house. Around two years later I started school. I had a pretty nice time until the first grade. Then I fell on some rocks. I dislocated my arm. Around seven months later I got hit in the lip with a key. I was taken to the doctor and had it fixed up.

"I had lots of friends. Then one day I was playing with my friends and I dislocated my arm again. I lived in Yonkers six years before I moved here."

The group grasped without difficulty the appearance of catastrophes coinciding so obviously in time and psychological equivalence with the unmentioned death of the mother in the story of Bob's life. The moving to strange places, including the school, was readily seen as related to the problem of adjusting to changes in the home after her disappearance. Easily interpreted by the group was Bob's next composition:

"My Life, Chapter 2

"On Memorial Day, when the dead soldiers were honored, I tried to go to the ball game. The tickets were sold out so I went home. When I got home I saw we had company. Then I cut my head on a picket fence and was taken to the hospital for stitches."

Bob's reactions to his stepmother and his teacher were not difficult to deduce, and the latter found her new insight most helpful in her approach to this problem pupil.

Rita, a pre-adolescent who made a habit of fleeing with repressed sobs and the creation of maximum hubbub from school assemblies, was demonstrated to be more than a hysterical girl attempting to attract attention; her need for help was found to be very real. Concrete ways of dealing with such situations in such a way as to create security and develop personality resources were discussed; the enlistment of school facilities and parental insight and coöperation were considered.

A typical problem in classroom managament, as influenced by the course, was illustrated by one of several similar reports:

"To help Johnny, a colored boy with low reading ability, who shuffled into my room during his first days of school with a loud song and dance, these are the things I have done. Many of the seemingly uneducable often have manual dexterity that is quite astonishing. This I have noted over a period of years, but until I took this course I did not realize that I could, by finding out wherein lay a child's talents, turn his behavior into something less negative.

"Johnny came to my desk after class and said, 'I can't read. You'll find it out before long anyway, so I thought I might tell you beforehand.' A few years ago, I would have thought I had to fail him and let him remain a problem to himself, to me, to his class. Since the administrators are more inclined than ever to give these non-readers a diploma, it remains for us, the classroom teachers, to live with these children and bring out whatever lies within them. It would seem to me, by so doing, we may be doing the only thing left for us to do, for at the nineteen-year-old level, a boy who feels he can contribute nothing and is abusively treated by the teachers can become a care to the state.

"So I said to Johnny, 'What can you do? Everybody has some talent. Some are good with books, some are good with their hands.' Johnny replied with alacrity that he was good in shop and offered to make some valence boards for the class. I was sceptical, but the next morning he took measurements and actually went to work. Soon he announced that the boards would not look good without drapes and suggested that he take up a collection in the class to buy material for this purpose. The other children were very responsive; one of the girls was able to procure

some beautiful material at wholesale price. Later Johnny went to endless trouble getting up his boards.

"When all was finished, Johnny was the proudest boy in school. His Harlem shuffle and noisiness had stopped and now he dreams of philodendron panels for the room. All this would not be worth the trouble and the time did I not note in his attitude a more manly appraisal of himself and an almost pathetic attempt to rate in English as well as in carpentry. He has learned to respect himself and I would not for the world have him resort again to cheap methods of getting attention."

Several reports stressed similar satisfactory results from similar methods applied to unpromising pupils, ranging from the intellectually deficient to the spastic paraplegic. Not only the children, but the teachers also seemed to be happier from these experiences. The group showed increasing insight in the use of school facilities. Cumulative records were used adeptly to trace the origin of individual problems and the personalities of the parents as well. In the case of one popular school newspaper editor who got into difficulties, a review of his reports and records showed an emotional isolation that had persisted from kindergarten despite superficial success in adjustment; the contributory attitudes of the parents emerged from the same sources. On the basis of her new insight, it was possible for the teacher to steer this boy through a scandal that might well have left permanent scars on a potentially promising career.

The attitudes of teachers themselves came up for consideration. Dynamically of particular significance was a last-ditch stand of Y, who endeavored to show how he had influenced a troublesome boy by threats of discipline. The group itself was able to point out to Y that actually he had felt and shown great personal interest in and kindness to this boy and that the threats of punishment were of significance only because of the positive bonds that had been established between them.

Many unsolved problems had to be left with the teachers. The question of how to use their new insight could not always be answered; the admonition to limit themselves to classroom goals was often frustrating. The questions of what to impart to parents, how deeply to go in their investigations, and how to deal with mothers and fathers who were impervious to the needs of deeply distressed children, were perplexing. Nevertheless, some part of the answers did emerge. Pupils could be helped; with patient persistence parents could be

taught; the teachers could relieve their anxieties and guilt feelings by conferences with one another. The ultimate goal of a psychiatrically oriented adviser in each school seemed the desirable solution, to the achievement of which teachers might bend their efforts and their influence. Practical possibilities in that direction were eagerly debated and reports on the achievements of other communities were reviewed.[1] In the meantime, most of the class (including Mr. Y), together with friends whom they recruited, secured the permission of the board of education for continuance of the course during the following semester.

To summarize, the introduction and development of psychological insight among teachers is one of the most important problems of prophylactic psychiatry. Such orientation must be in terms of educational, not therapeutic goals, and the establishment of productive interchanges between educators and psychiatrists raises many problems. Each has much to learn from the other, however, and there can be no doubt that future trends will integrate education and mental hygiene with increasing certainty.

[1] See "Beginning School Guidance Early," by Evelyn D. Adlerblum (MENTAL HYGIENE, Vol. 34, pp. 600–10, October, 1950); "School Mental Hygiene," by Jack Hertzman (*American Journal of Orthopsychiatry*, Vol. 20, pp. 529–46, October, 1950); and *The Rôle of the School in Preventing and Correcting Maladjustment and Delinquency* (New York: Board of Education, City of New York, 1949).

INTERRACIAL PRACTICES IN MENTAL HOSPITALS *

RUTHERFORD B. STEVENS, M.D.
New York City

IN recent years, social scientists have shown an increasing interest in racial prejudice, and many studies concerned with this subject have been undertaken. Since psychiatrists, with a new consciousness of the rôle social issues play in mental health, are studying this problem, it appears pertinent to investigate the interracial practices that prevail in psychiatry's own domain—the mental hospital. This study may be considered a first effort to obtain data on such practices in non-federal mental hospitals of the United States.

It should be pointed out that some states have laws on segregation in hospital facilities. Thus Georgia, Mississippi, and South Carolina have provisions requiring segregation generally in hospitals. Alabama, Georgia, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, Tennessee, Virginia, and West Virginia require separation in the case of mental patients. New York and New Jersey have laws that prohibit racial segregation in public hospitals.[1]

An effort was made to obtain information by sending a letter and questionnaire to 253 public and 191 private mental hospitals and sanitaria in the U. S. The names and locations of these institutions were obtained from lists furnished by the Publications and Reports Section, Federal Security Agency, Washington, D. C., and The National Committee for Mental Hygiene, which appear to be the most complete lists available. The letter and questionnaire were addressed to the superintendent of each institution. The questionnaire consisted of two parts: Part A requested statistical data relative to the numbers of white and non-white patients and

* A report based on a study made by the Committee on Social Issues of the Group for the Advancement of Psychiatry. The author wishes to acknowledge the valuable statistical help generously given by Louisa Franzen.

[1] See *State Anti-discrimination and Anti-bias Laws*, prepared by the American Jewish Congress, New York, October 1, 1948.

personnel in the institutions; Part B contained questions directed toward eliciting information about interracial practices in operation in the institutions and the attitudes of the administrative official.

In the first survey, responses were received from 107 public and 72 private hospitals. A follow-up survey was made approximately six months after the first, in which letters and questionnaires were sent to the superintendents of institutions who had not previously responded. From this effort, additional responses were received from the administrative officials of 84 public and 33 private institutions. Altogether, 296 responses were received from the 444 institutions to whom questionnaires were sent.

The study has several shortcomings. The source list of mental institutions did not include the psychiatric sections of general hospitals. The written-questionnaire method was used exclusively. Furthermore, questionnaires were directed to superintendents, who in some instances may not control the interracial policies of the institutions. In an effort to avoid an unduly long questionnaire, information was not requested about psychologists, social workers, and some other categories of professional and technical personnel. No evaluation is attempted of the situation in the 32 per cent of private and public hospitals that did not respond to the survey. This investigation must, therefore, be considered only a first approach to this problem.

A wide variety of interracial practices were found to exist in the mental institutions. Many institutions, especially private institutions, had an entirely white staff and patient population. Two public hospitals, one in the South and the other in a border state, had an entirely Negro staff and patient population. Most public and a few private institutions had mixed patients or personnel or both and reported almost every possible method of handling patients and personnel who were members of the minority group. Data were obtained on these varied methods in relation to the patterns of segregation or non-segregation of Negro patients in the wards and dining rooms and in recreational activities. Data were also obtained on the methods of utilizing Negro personnel. The information obtained from the voluntary comments

and remarks of the officials who answered the questionnaire has proved of great value in increasing our understanding of these practices.

The first question in Part B of the questionnaire had to do with the placing of Negro patients in the hospital. The responses from most public institutions of the South indicated that Negroes are usually completely segregated, with placement in separate buildings. Typical comments from administrators of southern hospitals are the following:

> "This institution maintains two separate units—one for the white patients and one for the Negro patients. There is race segregation in all instances."

> "We have separate buildings. This is the South and we have them quartered as is the custom here, which is more satisfactory to them and to us."

Most public institutions in the northern and western states placed Negroes without regard to race. A pattern of segregation was found most commonly in the border states. Nevertheless, in several instances, interracial practices varied considerably within the same state. Compare, for example, the following comments from administrators of two public institutions in one northern state:

> "By and large, Negro patients are housed in separate wards because they prefer being with their own race. However, Negro patients are also placed on wards with white patients, particularly surgical, medical, and open or parole wards."

> "We do not segregate the races in treatments or in any of our staffing programs, and have found absolutely no difficulty in handling the patient in this way."

In the first of these institutions, 9.8 per cent of the hospital population were Negroes; in the second, 16.7 per cent.

A comparable discrepancy is found also in the comments of two administrators from state hospitals in a border state:

> "Separate wards. As far as possible we feel it is best for them to be by themselves."

> "Random placement. No reason to regard Negro any differently than white."

The percentage of Negroes in these two hospitals was, respectively, 3.4 per cent and 16.7 per cent.

These divergent practices are particularly interesting in view of the fact that many administrators explained their

discriminatory policies as in accordance with community traditions. The differences in the proportion of Negroes in the four hospitals should also be noted. It is a frequent assumption that segregation rises with the percentage of Negroes in the population. In the instances quoted above, however, within the same state, segregation is not practiced when the proportion is higher. These few figures are, of course, not conclusive. They do, however, suggest that the subjective factor of administrative policy is more important than the objective factor of proportion.

Twenty-three of the 105 private mental hospitals responding to the questionnaire indicated that they accept Negroes as inpatients; actually, Negro patients were present in only 16 of these at the time of inquiry. Four out of the 23 expressed a policy of segregating the Negro patient from other patients. Eleven expressed a definite attitude of non-segregation. The other eight private institutions did not state their policy. In many private institutions, however, all patients are in separate rooms and take their meals in their rooms, so that there may be little difference in the practice of policies of segregation and non-segregation. Two of the private hospitals that accept Negroes are located in the South.

Practically all of the private hospitals that accept Negroes indicated that very few are referred to them and they rarely have more than one or two Negro patients at any time. An interesting comment from a private institution in California stated:

> "We do know that we are the only private sanitarium in — County which accepts Negro patients and while the demand is limited, we do get what there is, and our having that reputation does not seem to worry any one."

The second question in Part B was concerned with the seating of Negro patients in the dining rooms of public institutions. In general, some form of segregation in dining rooms was present in all institutions in which segregated placing in wards was in effect. A few hospitals followed a policy of non-segregation in the other areas studied. An administrator of a state hospital in a western state commented:

> "Our percentage of Negroes is so small our only segregation has been to seat them at their tables when in the dining room. Other than this they are treated the same as white."

The question of serving food to Negro patients in private hospitals appears unimportant since patients in these institutions are so frequently served food in their rooms.

Question 3 in Part B of the questionnaire had to do with methods of handling Negro patients in recreational activities. In public institutions, less segregation was found in this area than in any other studied. Of the 147 public hospitals with mixed populations, 125—28 of them in border states and 97 in the North or West—reported racially mixed teams or groups.

In view of the small size of most private institutions and the very small proportion of Negro patients, interracial recreational activities practices in their institutions are of negligible interest.

The fourth question in Part B of the questionnaire dealt with the utilization of Negro personnel. One hundred and thirty public hospitals with mixed patient populations replied to this query. Of these, 34 employed Negro personnel—8 of them Negro physicians, 15 Negro nurses, and 32 Negro attendants. In 8 hospitals Negro personnel attended Negro patients only; in 25, both Negro and white patients; and in 1, white patients only.

The numerous comments from administrators suggest that there are almost as many different attitudes towards employing Negroes as there are administrators:

> "Negro attendants and dietetic help have proved satisfactory if selected as carefully as white help."
>
> "We always state we are willing to have colored employees at the same ratio as colored patients. . . . 1.9 per cent colored patients equals 1 attendant."
>
> "In this section of the country, Negro doctors would be supposed to attend only patients of their race. We find white doctors attending Negroes is better. We have all white doctors at this time. Our Negro doctor resigned last year. We found it better to handle our Negroes as is the custom in this section of the country. They are happier and better satisfied with our method than they would be otherwise."
>
> "We do not employ Negroes because our physical set-up does not provide living quarters for them, and although the hospital administration has no prejudice against colored help, this lack of suitable quarters for housing prevents our employment of Negro help."
>
> "Colored employees . . . no difficulties have arisen either among the other employees or patients traceable to factor of race. White patients have

accepted the administration of a colored dentist, Oriental physician, and Negro nurses when . . . serving in the institution."

"Applications from Negroes are increasing and at times it is rather difficult to refuse them employment. It looks like we will have to accept them before too long here in —."

"[We are] fortunate in that the Negro attendants reside in nearby city and sleep at home and have an eight-hour day. We have employed but two in the past year. They have been quite satisfactory."

"No problem. There occasionally arises the question of colored attendants on the wards or even colored specialists in the field of sociology and psychiatry. So far we have hesitated because of the marked colored question existing in some of the counties which we serve, yet apparently no one even comments regarding Negro patients living among the white patients from these counties."

"Do not segregate [patients]. We do not employ Negro personnel owing to our nearness to the Mason-Dixon line."

With the exception of three hospitals associated with universities, no Negro physicians were found to be employed by private mental institutions. Four employed Negro nurses, and 11, Negro attendants.

Question 5 of Part B provided space for any additional information the administrator considered useful. Many expressed opinions about various aspects of interracial relations in mental institutions or enumerated incidents from their own experience. Attitudes and feelings expressed in the comments were of much value in revealing the attitudes of administrators, particularly when they came from states in which there was an opportunity for choice.

Many comments indicated that administrative officials held convictions for or against racial discrimination in mental institutions. Some administrators apparently enforced practices in keeping with their convictions, even when those practices conflicted with policies expressed in the laws of the state or the customs of neighboring institutions. The convictions expressed by other administrators were contrary to the practices within their own institutions. This was most frequently explained by "inability to combat the customs of the community." In a number of instances, administrators indicated that the mixing of races proved to be a satisfactory and effective arrangement. As one administrator stated:

"Our experience has been singularly painless in discouraging all discrimination as to race or color."

A variety of methods of handling complaints of white patients were described:

> "If occasionally some individual patient complains about the near Negro, we find it easy to separate the two and thus end the dissension."

> "We have on two occasions told white patients that they have to leave the sanitarium if they make another discriminating remark. . . . On one occasion we have typed a little note—'We are all created equal'—and have placed it on the table where the patient was seated. Giving publicity to the discriminating remark was enough to eliminate their reaction at this time."

> "We have an occasional colored patient and it is our practice to confine the patient in his room if the white patients object to associating with him."

> "Patients ordinarily do not object to the lack of segregation. If, in rare instances, objection is raised, correction of the attitude is attempted; if unsuccessful, the objection is disregarded. In fact, I believe some corrective pressure is brought to bear by more intelligent patients."

Most of the administrators from the South expressed definite convictions that complete segregation was the method of choice in handling Negro patients. It should be noted that the replies from two states in which separate hospitals for Negroes are located almost all included a statement referring to the separate hospital and indicating that they have no problem. The following is a typical comment:

> "— has provided a separate hospital for Negro mental patients . . . consequently there is no problem in respect to race here. No Negro attendants are employed."

Other non-white groups, such as Mexicans, Indians, and Chinese, were treated in a variety of ways. In the case of these groups, the occurrence of segregation seems more definitely related to their proportions in the population.

> "I would say that locally there is more discrimination against Mexicans than any other groups."

> "There is some reciprocal prejudice between the Anglo and Spanish Americans. . . . Contrary to Negro prejudice, the Anglo prejudice against Spanish-Americans is strongly apparent in the sections of the state where the Anglos predominate. . . . Perhaps because the sections have a large number of Texans and other southern emigrants."

As we have shown, the number of Negro professional personnel employed in mental institutions is small. A larger number of institutions employ Negro attendants, although usually in small numbers. Some southern institutions employ

Negro attendants in the Negro sections of the public hospitals. In other areas a wide variation of attitudes were expressed concerning the hiring of Negro attendants. Often a difficulty in housing Negroes was pointed out as a primary reason for not hiring them.

> "This institution maintains two separate units—one for the white patients and one for the Negro patients. There is race segregation in all instances. Colored employees work on the colored wards and white employees work on the white wards. Colored and white dormitories are separate. However, the same care in every respect is given the colored patient as is given the white patient—medical, surgical, housing, food, etc. All the members of the staff are white doctors even on the colored service, though we have in our colored general hospital 2 graduate colored nurses."

> "The city ordinance of [a northern city] does not allow a Negro to stay overnight in the city. Therefore, we can rarely employ Negroes."

> "No living accommodations, no [Negro employees] . . . A Chinese employed; no white man would work for the kind of wages paid."

> "During the war, when we were first faced with a serious shortage of attendants, we decided to accept colored attendants. There was much remonstrance on the part of some of the white attendants as at that time we had a large number from the South. I personally met the group and after a discussion which seemed to achieve little, we proceeded with our plan. None of the white attendants resigned, and if any unpleasant instance occurred, it did not come to my ears. The colored attendants were merely shown the dining room and took seats as they wished. Sometimes they sat together and at other times they did not. Throughout, it has been a matter of their choice or convenience. The same plan was followed in housing them. We have made it a point to have a few on the same floor and using the same bathrooms as the white attendants and have no official complaints or difficulties."

In responding to the survey, many administrators made special comments which indicated a preoccupation with their inability to obtain sufficient personnel, particularly nurses and attendants. Of course, the general shortage of nurses and attendants in mental hospitals is known to all who are interested in psychiatry. In this connection it is noteworthy that the questionnaire responses show that Negro attendants have proved eminently satisfactory wherever their services have been utilized. The fact that Negroes are at a disadvantage in obtaining work for which they are qualified encourages many with better-than-average education and training qualifications to accept these positions, when available. The relatively small number of Negroes employed as attendants suggests that in many regions of our country there is an untapped reservoir

of personnel, the use of which should lessen the burden of caring for the mentally ill.

The situation is quite different in respect to the employment of Negro nurses and psychiatrists, since very few Negroes have received training in these fields. About twenty of America's five thousand psychiatrists are Negroes. While the scarcity of Negro professional psychiatric personnel partly accounts for the very small number employed by mental institutions, it also points up the necessity of providing training for a greater number of those who are qualified.

Many administrators seem to fear that the employment of Negro personnel will cause "trouble," in that some of their other personnel might leave. This fear has been proved unwarranted in the many occupational areas in which the barrier of racial difference has been removed in recent years. The last "comment" quoted is eloquent testimony that employees of mental institutions will not react differently.

Administrators in the southern sections of the country were almost unanimous in the opinion that complete segregation is the method of choice in handling Negro patients. The fact that complete segregation was the system of communities around the hospital was frequently offered as a reason. Because of this system, there is little doubt that many administrators would find it difficult to do away with segregation in their institutions even if incontrovertible evidence were provided that a racially integrated environment was the more effective in aiding patients to recover from mental illness. There is very little evidence to support either side of this question, and there is need for further factual studies based on actual experience for the purpose of determining what can be done.

A few administrators described personal experiences[1] during World War II in which a policy of non-segregation was adopted in certain military hospitals located in the South without the difficulty anticipated by many members of the staff. It is known, also, that numerous white and Negro mentally ill patients from regions of marked racial discrimination and segregation have been successfully treated in non-discriminatory hospital environments without evidence of detri-

[1] Not quoted in this report.

mental effect from the change in interracial practices. This experience is very common in hospitals located in border states with a large out-of-state population, such as the Winter Veterans Hospital in Topeka, Kansas.

Most southern administrators expressed the belief that Negroes prefer to be segregated. Certainly there are many Negroes in the South who would state such a preference. This is not surprising, however, when one considers the inferior position of the Negro and the necessity upon him to "adjust" to members of the white race. This also needs further study directed towards evaluating the "adjustment" and the necessity for it. Only one administrator of an institution outside the South expressed the opinion that Negroes prefer segregation.

The survey responses seem to indicate that many psychiatrists, as a result of their personal experiences, feel that intergroup tension and prejudice represent a disturbance in the sphere of mental health as well as in the social relations and adaptation of individuals. Perhaps research in the fields of group psychology and social and interpersonal relationships will give definite answers as to the effect of racial discrimination and segregation on the mentally ill. Since scientifically acceptable answers have not yet been provided, some psychiatrists in administrative positions have acted in accordance with their beliefs in the principles of democracy and have removed the barriers of racial segregation and discrimination in their institutions. Responses to the questionnaire indicate that they did so with a minimum of difficulty. Certainly others can do likewise. As Thomas L. Peacock has said, "What is, is possible."

MODELS OF CHILDREN'S PLAY

LILI E. PELLER

The College of the City of New York, School of Education

CHILDREN'S play, and especially the various rôles and characters incorporated by them in their "dramatic" play, have been the subject of many comments both inside and outside of the psychoanalytic school.

Until recently, academic psychology assumed an "instinct" to imitate that prompted a child to copy whatever he chanced to observe frequently enough and long enough. Freud pointed out, in *Beyond the Pleasure Principle,* that it is not necessary to assume a special instinct to imitate. There is no imitation without an emotional motivation. A child's play is not like a mirror which necessarily reflects what is within its "sight." The child is highly selective in the behavior he imitates. His choice of a rôle follows certain principal lines.

This paper presents a number of "models" or formulas of play activities, and illustrates them with examples culled from our experience and from literature. Undoubtedly this survey is incomplete. Even so, it may stimulate further observations and new interpretations of the material at hand.

Choice Based on Love, Admiration.—A child pretends to be some one whom he admires and loves and whom he would like to resemble. By and large, admiration and wishful anticipation of his own adult rôle determine the rôle he chooses. This is the type of children's play that adults find most amusing and that has been most frequently described, not only in psychological literature, but also in novels and poems. The child plays at being mother, father, or teacher; he pretends to be a king, a queen, or a fairy. At play he recaptures a fragment of his ancient belief in the omnipotence of wishes. He enjoys a power and prestige denied to him in reality.

When adults speak of "happy childhood," they probably have in mind the child who hobbles around in high-heeled shoes or who has draped around himself some piece of adult clothing and thus has jumped with great ease the gulf between wishing and being.

On closer investigation, however, the situation is not quite so carefree and happy. Admiration alone is seldom the basis for the child's choice; as a rule, there is an admixture of frustration, deprivation, or fear.

> Michael, aged three years and eight months, has refused to go to nursery school, although all his friends are going there, and he thus remains without playmates in the park. Whenever a passer-by starts a conversation, asking his name, and so on, he answers, "My name is Michael Schoolboy," saying it with so much assurance that people are inclined to believe him.

There can be little doubt that Michael would like to go to school and be with his friends. But he cannot bring himself to leave his mother. In his playful change of name, the conflict is solved. He *is* a schoolboy. In fact, in almost every instance of such play one finds an element of fear or of envy accompanying the obvious admiration and love.

A Rôle Assigned to an Inanimate Object.—In a variation of the type of play discussed above, the child does not himself assume a rôle, but appoints a doll or a toy animal—or it may well be a pillow, a piece of wood—to the rôle of the child, the baby. To have some one depending on him indirectly changes the child's status. Or the child pretends to have an imaginary companion—a brother, a sister, or a dog.

> Popsy made his appearance when Billy was about three and a half. We first became conscious of him when driving in the car. Billy always urged his father to pass other cars on the road and get to the "head of the line." But when a car passed us and sped ahead, Billy would chuckle, "My Popsy is driving that car. Doesn't he go fast?" Sometimes Popsy rode on the roof of our car. Sometimes he jumped from treetop to treetop beside the roadside as we went by.
>
> Once when we commented on an attractive new schoolhouse, Billy remarked, "My Popsy is a teacher in that school." That same night he got uncovered and called. As his mother tucked the blankets around him again, he whispered, "Popsy pulled those blankets off of me. Isn't Popsy a nuisance?"

The wishes, peculiarities, and possessions of this imaginary family member have to be respected. In a casual, apparently unintentional way this may give the child a chance to retaliate for some of the things he experiences. In a disturbed child, this mechanism is intensified and thus more obvious.

> "David, aged two and a half, a very nervous child with a highly nervous mother, seemed quiet and comparatively happy in the first two days in the residential nursery. He was inseparable from a toy dog,

Peter, whom he had brought from home. Peter slept with him, ate with him, was in his arms even when he was bathed and dressed, and David insisted that Peter should be taken care of as if he were another child in the nursery.

"When his mother visited him after two days, David had his first temper tantrum. He insistently demanded that she should kiss Peter on the mouth and hug him as if he were her baby. From then on and for quite a while he reacted with temper to any imaginary slight done to Peter. He would cry whenever another child would knock against the toy and would throw himself on the floor with despair whenever the dog inadvertently fell out of his arms. Peter is evidently a symbol for himself and has to be treated as he himself wants to be treated. His mother has to make up in affection to the dog for the wrong she had done to David by sending him away from home."[1]

The pleasure a child derives from his doll or Teddy bear stems largely from this source. The young child who is not under severe emotional pressure will play in this way intermittently, now feeding the Teddy with remarkable patience and carrying it with great care and a little later flinging it around carelessly. He assigns a rôle and forgets about it with equal ease. The significance of this type of play changes with the child's age. The five-year-old may play the maternal rôle all day long, but the two- or two-and-a-half-year-old, who is consistently gentle with his dolls, has in our experience been a person burdened by too many worries.

Barbe, aged three, lost her father in the war. Her grief-stricken mother has not been able to explain the father's absence to the child and consequently B. has a number of fears. For instance, she is terrified of the Santa Claus in the department store and does not even want to go near the store.

The consultant who sees mother and child presents Barbe one day with a chocolate Santa Claus, whom she takes with evident pleasure and no fear. Before leaving for home the mother wants to put the chocolate figure into a box, explaining that otherwise it might get broken, but Barbe objects. The mother proceeds to put it in anyway. Barbe is in tears. Her mother is highly annoyed with her unreasonable behavior. Barbe is alternately screaming and imploring her mother not to put Santa into the box.

At this point the consultant suggests making slits for air in the box and that solves the situation. Barbe calms down and permits her to put Santa Claus into the box. The child would rather dare her mother's anger than risk displeasing the chocolate figure.

Choice Based on Fear.—Whenever the child takes on the rôle of some one whom he fears, anxiety or frustration deter-

[1] See *War and Children*, by Anna Freud and Dorothy T. Burlingham. New York: Medical War Books, 1943. pp. 133–34.

mines his impersonation. Several of Freud's classical examples follow this line: a child plays at being the doctor, after the doctor has administered a painful treatment or performed a minor operation. Anna Freud reports the case of the child who conquers the fear of crossing the dark hall by pretending to be the ghost she dreads to encounter. By choosing the rôle of the doctor or the ghost, the child can switch from the passive to the active rôle and inflict upon another person—be it a child or a doll—what has previously been done to him. The change from a passive to an active rôle is the basic mechanism of many play activities both of children and of adults. It mitigates the traumatic effect of a recent experience and it leaves the player better equipped to undergo the passive rôle again, when necessary. This accounts for a great deal of the healing power of play.

The Losing Party.—In observing children at play, we see that while the dominant aggressive rôles are preferred, there is always some child willing to submit to the assault, to take the rôle of the sick child who has to swallow medicine and is sent to bed, or, in war play, to take the rôle of the hated enemy soldier who is invariably defeated. How can this be explained?

Several explanations suggest themselves. The very simple and non-psychological one is that a younger or less popular child fears that he will be excluded from the play altogether unless he takes such a rôle. Another explanation is that we have here early passive or masochistic tendencies. Finally the behavior can be explained by giving a broader meaning to the mechanism of "turning from the *passive* to the *active* experience." A child who himself chooses or consents to be the passive, the victimized party and knows that he can terminate this rôle whenever he pleases is not really passive. Even in the inactive rôle, he is self-steered and not a play ball.

Incognito Indulgence.—In contrast to the rôles described so far, which in the child's scale of values go in a direction "beyond and above" his present status, the child also chooses rôles that are distinctly "passed and below" him. For instance, he plays at being an animal or a baby. Freud states: "The wish which dominates childhood is the wish to be big and adult and do as the adults are doing." Why, then, should

a child slip into a rôle that limits the powers he actually possesses?

Such a play rôle provides a convenient disguise for enjoying pleasures that are no longer compatible with the youngster's sense of his own dignity and grown-upness. This motivation can be understood if we consider how the young child is torn between two worlds. His superego takes its standards from his parents and teachers, whom he wants to please. Often, however, he cannot give up childish pleasures as quickly as he is expected to. Aware of the "subversive" elements in his own house, the superego of the early latency years is especially strict. Yet by announcing, "This is not me. It's a puppy dog," the child can permit himself to enjoy sniffing, crawling, getting dirty. By declaring, "I am a baby now," he can cuddle up, suck his fingers, insist on being carried around, talk gibberish. A child living under great pressure to be sensible and grown-up is more likely to select a rôle along this line. In one and the same play situation, a forbidden wish can be simultaneously expressed and disclaimed.

L., not quite five years old, insists for weeks and months daily on the following morning ritual: Her mother must greet her, "Good morning, Bambi." L. replies: "Good morning, Feline! You know, Feline, my mother died. Will you be my friend now? " To this her mother must answer: "Yes, Bambi. I'll always stay with you."

Often L. continues this rôle all day long. She has borrowed this scene from the Bambi film. There Bambi's mother is shot and killed by the hunter and the lonely and distressed Bambi finds Feline in the forest and lives with her forever after. L. is a girl with many problems and her death wishes against her mother and the consequent fear that they will come true are particularly strong. About a year ago her baby brother was taken to the hospital where he died suddenly. Now L.'s mother is pregnant again and L. is terribly afraid and pleads with her not to go to the hospital.

In the past month the rôle of Bambi has provided L. with an excellent outlet for her own double-barreled wishes.

Bambi's mother was a deer, and people don't take it so seriously when a deer dies. After that sad event Bambi felt lost and lonely, but he got over the loss; so a human child would get over it, too, and find other friends, should his mother die. In the Bambi camouflage, loss and consolation can be lived through in phantasy without feelings of guilt.

It must be remembered that a child frequently assigns a rôle to an animal completely different from the one discussed here. A wolf, a horse, sometimes also a dog or a rooster may be symbols of great power and ferocity. In our examples,

animals are a kind of "second rate" human beings. They feel and talk like human beings, yet they may indulge in actions that the child would consider beneath his dignity. After all, they are "only" animals and it is not upsetting when they lack the restraint expected in *homo sapiens*. On the other hand, it is permissible to do things to them that would be unthinkable with humans.

This type of play might be called "incognito indulgence." The child lends his motor apparatus to one part of his self and holds his superego in abeyance by declaring: "That's not really me. You don't have to interfere." As in any make-believe, there is the implicit assurance, "All this is for a limited time only."

The prototype of this play mechanism is the dignitary, the Caliph Harun-al-Rashid or the Emperor Joseph II, who, shrouded in a cloak that provides convenient incognito, can visit all kinds of lowly places where he could not be seen if recognizable as himself.

An animal can enjoy feelings or show character traits that would be repulsive or cause feelings of guilt and shame in a human being. He can also be treated in a way that would be punishable if used toward a person. It works conveniently both ways, whether the animal is the subject or the object. The heroes of some of our most beloved children's stories are animals and thus can go through dangers and ordeals that would be outrageous in the human world.

Take Peter Rabbit. He really is a disobedient and greedy little boy who runs away from home. At the climax of the story, after stuffing himself with forbidden delicacies, Peter is chased by the old gardener who wants to kill him and put him into a mince pie. It would be outrageous in our day and age to tell such a story about a child. But story-teller and listener agree to call the hero a rabbit, and the plot can become more dramatic and much truer to the young child's hidden anxieties.

In more than one way this story follows the line of archaic childish reasoning: the impending punishment fits the crime. Peter is in a predicament because he ate forbidden things and now the gardener is going to eat him. It is tit for tat. As the story draws to its close, this horrible punishment is mitigated

to one that is more likely to befall a naughty little boy: Peter is sent to bed without supper. But even this punishment still fits the crime. The characters in *The Wind in the Willows,* in Dr. Doolittle's books, and in many children's classics act in accordance with this "logic."

Seeing only the superficial, conscious aspect of a story, educators have at times objected to the unbiological thinking that is fostered as animals strut on their hind legs, talk, and are dressed like human beings. Yet more than 2,000 years ago when Æsop wanted to chide and deride human vices and weaknesses, he hit upon the same device; greed, vanity, and stupidity are somehow less offensive when encountered in animals. The implied accusation becomes less direct and loses its sting. After all, what can one expect from a fox, a peacock, or an ant?

The most recent and possibly the most popular addition to the long list of animal masks for human follies and foibles are Donald Duck, Mickey Mouse, and their consorts. In five minutes flat, the hero of an animated strip undergoes a series of atrocities that no exaggeration and no colorful details could make funny if they were happening to a human being.

Clowning.—Another mask that provides a convenient incognito is *clowning.* For instance, a child in a kindergarten has put on his cap the wrong way. He could correct it quickly and hope that none of his playmates noticed his blunder. (He would not be playing then.) Instead, he chooses another road: he repeats his mishap deliberately and in an exaggerated form, putting it, so to say, between quotation marks. Now he draws everybody's attention to his mistake, and he does not feel bad about it any more—just the opposite. After all, it is plain that he *chooses* to act this way.

The observation of a clowning child shows that there is more than one way of turning the tables, of switching from the passive to the active rôle. The clown does to himself what fate tried to do to him. That he gets plenty of attention may be called a secondary gain. The primary gain is that he need not admit—either to himself or to others—that he committed a blunder the first time. By deliberately repeating and paraphrasing it, he makes himself master of the situation.

A group of seven-to-nine-year-old campers stand on the platform near the train. Suddenly the locomotive releases steam with a loud hissing noise.

H., who stands near it, almost jumps with fright. He notices that the others are looking at him, about to laugh. An embarrassed smile comes on his face and as the hissing recurs a few seconds later, he repeats and exaggerates his former movements. He throws his arms up, shrieks, and almost tumbles over. He repeats these antics with every blast of steam. Now he has the laughers on his side; he is the hero who parodies getting scared. He is not the victim of the situation, but the victor.

Clowning differs from the other models of play in that it requires an audience. It is as if the clown were saying to fate: "You thought you could lick me by showing me up as clumsy (or stupid, or ugly, or queer-looking). All right, I am not just a little clumsy (or ugly), I am very much so, but on my own choosing. You did not do it to me." Contrary to the other make-believe changes—"I am not envious or afraid. I myself am the giant, the king, the bogeyman"—this reversal cannot be enjoyed without the appreciative mirror of an audience.

Hiding one's own identity under the cloak of a clown, an animal, or a baby differs also in another aspect from the other paradigms of play discussed here. The others may be called *pre-stages of identification.* Being unable to achieve in reality a happy ending, an active rôle, or the strength of the aggressor, the child brings, at least in his play, things "into another order, more satisfying to himself." But in the incognito mechanism, the child adopts a way of acting not in order to incorporate it into his own person—as, for instance, in the identification with the aggressor—but in order to accentuate the distance, the veritable gulf between himself and such behavior. *"Facio quia absurdum,"* seems to be the principle of his actions. He rids himself of childish and ostracized impulses by acting them out drastically and copiously. He lends his motor apparatus to one part of his self while the other part—or his superego—pretends to be an uninvolved observer.

There are other instances in which we treat our own self as if it were another person and deal with another person as if it were our own self. There is, for instance, the mechanism that Anna Freud has called "altruistic secession," whereby we grant to and even encourage in another person an indulgence that our own conscience does not permit us.

Another example is the young child who tattles to his mother or teacher about the misdeed of a brother or a play-

mate. His denunciation of the other is not primarily malicious, as it might be in the case of older children or adults. Well enough does the young child know that he himself harbors similar "bad" desires. He uses his playmate to gain relief from his own guilty conscience.

In clowning, the child's superego disclaims what his bodily self does, while in tattling he clamors for the punishment of another person's misdeeds in order to atone for his own similar desires. In all these phenomena the gulf between superego and ego is temporarily wider than the distance between superego and another ego.

Thus far we have discussed *whose rôle* the child takes over and *why* he does so. Now we will follow another lead: to what extent do elements of the child's play copy a recent exciting or traumatic experience and to what extent are they *variations* of or *additions* to the past event. From the actor we turn to the plot.

Deflected Vengeance.—A child may suffer severe frustration without showing hostility against the person who disappoints or thwarts him. Instead, he vents his feelings on another person or on an object, often on his toys. Here the hostility is *deflected,* as in the classical example of the play with the bobbin.

> "The child (about eighteen months old) used all his toys only to play 'gone' with them. He had a bobbin with a piece of cord fastened to it. He never thought of pulling it, for instance, along the floor, playing cart with it. Instead, he threw it with great dexterity into his crib which was covered so that the bobbin disappeared, saying his ominous 'O-O-O-O-' and then he pulled the cord so that the bobbin reappeared. . . . He greeted its appearance with a joyous 'da.'
>
> "Now the interpretation of this play was not difficult. It was connected with the great cultural achievement of the child, with his successful renunciation of instinctual gratification in permitting his mother to leave without remonstrating. Now he got even, so to say, by enacting the same disappearing and returning with the objects within reach. . . . The throwing away of an object, so that it was gone, could be the gratification of an impulse of vengeance against the mother for her leaving which in real life was suppressed. It could have the defiant meaning: 'Go away! I don't need you. I even send you away.'"[1]

Since it is impossible to avoid frustrations and disappointments in the child's daily life, this type of play can be observed in every nursery.

In a variation of this formula, only the *mood,* the general

[1] Sigmund Freud in *Beyond the Pleasure Principle.*

feeling tone, is taken from a recent traumatic experience, but the child's play actions do not copy the action to which he has been subjected.

Anna Freud has given an illustrative example of a six-year-old boy who had undergone dental treatment and came to his analytic hour in a very bad mood.

> "The dentist had hurt him. He is angry and unfriendly and starts maltreating the things in my room. His first victim was an eraser. He wants me to give it to him as a present. I refuse and so he wants to cut it in half with a knife. Then he turns to a big roll of cord and wants this as a present, explaining to me how well he could use it as a leash for his animals. Again I refuse and so he gets a knife and at least cuts off a long piece for himself. But he does not use it. Instead, he cuts it all up into small pieces. Then he rejects the cord, turns to the pencils, and starts sharpening them indefatigably with a knife, breaking off all the points and sharpening them again and again. It would be wrong to say that he plays at being a 'dentist.' The image of the dentist does not enter his behavior. *His identification does not concern the person of his adversary, only his aggression.*"[1]

In our work with nursery schools, we frequently observed the following behavior: A little girl mercilessly spanks her dolls, puts them to bed for punishment, pushes them around, and so on. The teacher, naïvely assuming that the child's behavior mirrors the treatment she received at home, takes the first opportunity to talk to the mother. When the mother asserts that the child has never been spanked, and that the parents believe in lenient and progressive methods of education as sincerely as the teacher, the latter is nonplused.

The child's play in such a case reflects the feeling, not the treatment she experienced. The little girl felt her mother's impatience, anger, or hostility and uses "poetic license" in finding actions to express it in her doll play. She treats her dolls as her mother may at times *wish* to treat her.

Anticipatory Retaliation.—The actual situation may be even further removed from the impression we gain from the play in the doll corner. The mother is unaware of any conflict or strain. Yet the child may be angry with her for one or the other reason. The child is the one who harbors hostile feelings against her mother and, therefore, expects her to retaliate. Indeed, with some children an unwarranted outburst of hostility against parent or teacher is a fairly reliable indi-

[1] *The Ego and the Mechanisms of Defense*, by Anna Freud. New York: International Universities Press, 1946.

cation that they have done something forbidden. The underlying reasoning (conscious or unconscious) is, "I am justified in doing this to you as you plan to do it to me." The child's attitude may be called "anticipatory retaliation." (Credit for coining this seemingly self-contradicting term goes to *Time* magazine. It was used in 1948 in a discussion of our relations with Russia.) This mechanism was discussed by B. Bornstein, who calls it a "prophylactic aggressive attitude" and described several instances in which a child "takes over an aggression that he anticipates."[1]

Conversely, a little girl may be extremely gentle and kind with her dolls—not because her mother treats her this way, but because she would like her mother to be so kind and loving with her.

This indicates how careful we must be before drawing any inference about a mother's attitude. The child's play with her dolls may follow any one of these formulas: This is the way mother treats me, or this is how she *should* treat me or, this is the way she *feels* toward me, or, this is the way she will treat me once she finds out what I have done.

Happy Ending.—In other instances, the child's play mirrors and repeats a former experience except that the ending has been reversed from an unhappy to a happy one.

> Shortly after Jonathan had moved from the city to a farm, he was playing with a visiting girl cousin in the yard when suddenly the lid of the dug-out on which the children were standing caved in and Eileen fell into the pile of manure it had covered. She struggled, yet sank deeper into the oozy mass. Jonathan stood petrified, torn between the desire to run for help and his unwillingness to leave her. Fortunately, somebody soon happened to pass by and rescued the girl. Months later, his mother overheard him repeating the incident with his toys. His commentary ran: "The boy fell in splash! . . . But he is a big boy. He can get out all by himself."

Many of the ambitious daydeams of latency and later years follow the same formula.

Magic (No Risk).—In another variation, the child repeats an everyday experience in order to gain the assurance that there will *always* be a happy ending, or, possibly, that it is within the child's power to bring about the happy ending.

"Hide and seek," the favorite game of most children

[1] See "Clinical Notes on Child Analysis," in *Psychoanalytic Study of the Child*, Vol. I. New York: International Universities Press, 1945.

between eighteen months and two years of age, is a case in point. The child "hides" in a nook or under the table and the mother has to look for him. He enjoys endless repetitions. At first sight this may seem a simpler version of the more skilled hide-and-seek play of older children. The real difference becomes obvious only after the adult, feeling that the act has been repeated in the same form often enough and is getting monotonous, tries to improve it by introducing variations. For instance, the mother begins to "seek" the child in places where she has not looked before and takes a longer time in finding him. But the youngster gets impatient and darts out from his hiding place, pointing at himself. "Look! Here I am!" Or the mother suggests that he hide in another corner, in a place where it will be more difficult to find him. This does not appeal to the child and he is apparently deaf to the remark that mother already *knows* the place where he had been hiding before. It does not matter to him, or it is more correct to state that this is exactly what he wants.

Thus the young child's hide-and-seek play follows a formula different from the game of older children. With them, it consists in pitting against each other skill and cunning in hiding and seeking, each player trying to outsmart the other. Each one hopes to win, but knows his risk of losing, and this suspense provides the spice of the game. The younger child's hide-and-seek game is but a pantomimic assurance: "Whenever mother is out of sight, I can reunite with her in a short time. *I* am the one who brings about our separation, and *I* can bring about our reunion. His hide-and-seek play resembles a square dance in which the couples part and weave their way in traditional figures through the dancing group to meet again.

"Goodbye, farewell, my dear old friend.
We'll meet again, you may depend.
We'll meet again ere long
In merry dance and song."

There is nothing new or unexpected in the stanzas and steps of a folk dance, yet the dancers enjoy the familiar sequence as the child relishes his well-worn pattern of play.

Manipulation and Playful Repetition.—In every type of play discussed thus far, some feature of reality is "canceled"—in fact, this cancelation seems to be the purpose of

the play. From the actor's point of view, his version or his assigning of rôles improves reality. Now we come to forms of play that apparently have no intention of undoing events or of changing the status of players; their only purpose is to broaden and to vary contact with reality, as in manipulative play, or to prolong an experience, as in playful repetition. Everyday examples are throwing a ball, letting sand run through the fingers, opening and closing a faucet, and so on.

Do these activities belong to true *play?* Are they not either plain enjoyment or rational forms of learning, aiming directly at the goal of acquiring a skill or gaining information? For the time being, let us note that to exclude them is to ignore an important and at times revealing segment of the child's interests. Later we may discover additional reasons that favor their inclusion in a survey of play.

There is no plot in these activities. The child does not step into any rôle; there is no drama, no climax, as there is in play instigated by Œdipal tensions, and the child's actions do not seem to have a symbolic value. In a way, these activities are the direct precursors of later experimentation, of the physical, chemical, geographical explorations of the older child.

But they are forerunners only, and they are to a large extent evoked or accentuated by the child's emotional problems.

Martin, five years old, habitually visits his grandmother several times a week. One day he notices an egg-timer which had been within his reach all the time. For a long time he sits still and watches the thin trickle of fine sand run, turning the small hourglass over and over again. This simple manipulation and observation fascinates him and he repeats it on several visits. This is in contrast to his usual active and roving behavior. For the last couple of weeks Martin had heard many allusions about a baby brother or sister who will arrive after Christmas, and this is the month of July.

L., aged two years and three months, builds for height with extraordinary perseverance and skill. She has wooden cylinders, 3½ inches long and with a base the size of a nickel, and she succeeds in putting four or five on top of one another before the structure collapses. It would be a skilful performance for a seven-year old.

She has a blackboard which she uses but little for scribbling. Instead, she makes a wet spot on it—then blows on the wet spot and watches it disappear. This, too, she repeats many times, showing an unusual patience.

L. has been seen by a consultant because she has outbursts of rage, and attacks her mother, biting and scratching her. Her difficulties could be traced to a traumatic castration experience. Her only playmate and the only person she ever saw naked was a cousin, a year older, a very

wild and aggressive boy. She also had very early and strict toilet training.

These are instances of seemingly purely manipulative play. The activity runs on and on in a rather monotonous way or possibly with a crescendo or diminuendo. Yet when the child's emotional problems become known, it appears that the manipulative activity carried out with innumerable repetitions was not chosen at random.

Of course, in a young child's day there is much playful manipulation that has no deeper emotional roots. It is characterized by less persistence, and the child does not become so oblivious of his surroundings, of other toys, of the ridicule of other people, or of parental prohibitions.

On the other hand, in children's so-called dramatic play with dolls, and so on, there are frequent interludes in which the ideational content runs low or gets confused and hazy and only the pleasure in some kind of manipulation or repetition keeps the children going.

Written records of children's family and household play have a tendency to gloss over its incoherences and sudden shifts. Adults are prone to read into the children's doings a progressive movement from one episode into the next. Yet the play of children under five usually resembles less a stage play and more a dream. There are duplications of persons and episodes, sudden changes of locality—all of which just don't make sense, not even to the observer who knows the players well. It is amazing how children can apparently enjoy playing "together" for a long time, their ideas clicking for a while—then go far apart.

The child may modify his handling of a material, using it in many different ways and thus exploring it, or he may just repeat what he has already been doing. The doing as such seems to be pleasant enough to induce repetition. K. Bühler has termed this kind of activity with no goal "*Funktionslust.*" The mere functioning, the activity in itself, brings pleasure. This method of play belongs to the youngest age group. It includes the child's babbling monologues in which he pronounces sounds and syllables, listens and repeats and varies them; the long spells of playing with his fingers, his toes, or a rattle. If any imagery accompanies this play, he may have vague hallucinations of gratification and grandeur. There

cannot be any plot, as there is no risk, no competition. In a sense, intending and carrying out coincide.

Manipulative play that is chosen with great persistence is related to the child's emotional tensions; it has symbolic value and merges into dramatic play. In later years, manipulative play—for instance, doodling—may return chiefly in stages of fatigue, or when a person is deeply preoccupied with an emotional or intellectual problem—in short, when part of his resources are drained off.

In academic child psychology, one often finds the statement that the younger the child, the shorter the span of attention. This is correct only when we try to force upon a young child materials and play methods that would be more suitable for older children. A child of eighteen months or two years when permitted to handle and explore mud, sand, or water will show remarkable perseverance and an even longer span of fully concentrated attention than older children with the same media and tools.

A play activity can belong to several models at the same time. For instance, Goethe's earliest childhood memory of how he threw all his doll dishes, one by one, out of the window and then let his mother's plates and cups follow because he enjoyed the cheerful clang of their breaking on the pavement outside, reads like an account of manipulative play. However, Freud's analysis shows that it was also an act of magic—namely, the symbolic eviction of a brother, who was about three years his junior. It was also an act of deflected vengeance. This shows that there is no rigid dividing line between various forms of play. Many of the things said here about the playing child are, with minor variations, equally true for the playing adult.

In conclusion, we may point out some of the teleological aspects of play. What are the benefits of play for the child? Several earlier play theories, especially Charles Darwin's, emphasized the acquisition of skills useful for the future adult, skills essential for survival in a certain environment. Playful repetition helps in the retention of knowledge and skill.

The psychoanalytic interpretation so far has stressed the emotional release gained through play. Children play in order to mitigate, to deny, or temporarily to solve a conflict.

In play the child recaptures for a while the omnipotence he once believed he possessed. He repeats and gradually assimilates an experience that was traumatic or a narcissistic insult. Play may help him to overcome a specific fear. And, of course, play is a source of pleasure. In addition to these emotional values, we would like to discuss the benefits of play for the child's intellectual growth, benefits that are certainly not the cause of play, yet are inherent in it. Let us go to the very simplest quality of play: the playing child *repeats* an experience he has had, or a part of it. *Repeating it, he divests it of its uniqueness.* An event that has no precedent will overwhelm even the best equipped adult. Such events happen seldom to grown-ups. We can usually classify an occurrence in terms of past events or at least draw an analogy. The adult can in his thoughts go over the event that upset him or that he did not quite grasp. Reliving it in thought, he *reduces* it from a unique experience to one that can be classified with previous experiences.

The young child, however, meets "unprecedents" all the time. He has only a limited ability to recapture an image by repeating its verbal label or by repeating it in thought. Impressions that are unique are not amenable to laws. Play enables the child to reëxperience, to remold past impressions and events and their accompanying moods and emotions. *Playful repetition provides essential, possibly indispensable steps toward concept formation.* Freud defines thinking as test-acting *(Probehandeln)* carried out with a minimum of expenditure of energy. By pointing out the similarities between thought processes and direct action, by looking for their common denominator, we gain a better understanding. Can anything be gained by comparing formulas of *play* with the act of thinking? At first this seems a ridiculous comparison, almost blasphemous.

Thinking is a way of acting that respects the laws of reality. Play is largely wishful thinking, and as such ignores the laws of reality and poses as a "cheap" substitute for reasoning. Moreover, in play the expenditure of energy is big. Indeed, the overflow of useless energy has been considered the cause of play (Schiller-Spencer's theory of play).

Solving a problem through play thus appears the opposite of seeking a solution through reasoning. Yet the two share

also certain features, above all the absence of direct and immediate consequences in the outer world. In thinking we pick out elements of reality and vary them; the same is done in play. Thinking is far quicker than direct action; steps taken in play can be instantaneous. Thinking requires imagination; so does play. Things that in reality are far apart in space or time can be brought into juxtaposition in the process of reasoning, but play also overcomes the obstacles of time and space with great facility. Play, as well as reasoning, is caused by an experience that was not concluded to our complete satisfaction. It was either too short, too sudden, unpleasant, or an insult to our ego, or we were not able to understand what was going on. Therefore, we are "at it," going over its various aspects in thought or play to be better equipped when it recurs or when we decide to seek it again.

Tentatively, we may say that a good deal of children's play is a crude kind of test action. In comparison to scientific thought, its tools are clumsy and inefficient. The adult in possession of the versatile symbolism of words can hardly estimate what it means for the young child to bring situations back by casting himself into different rôles, by play and pantomime. Play not only helps the child in his emotional adjustment; play activities are also the matrix of future realistic action and reasoning.

In conclusion, let us revert to the mechanism that seems to be at the root of most play: the turning from the passive to the active rôle. Being "passive" has several distinct meanings. It may, for instance, signify being physically inactive; it may also mean not knowing what to expect, being at the mercy of forces that the passive person cannot understand or predict, or being overwhelmed by a force or a person. Conversely, being in the active rôle may have any of the following meanings: being physically active, being informed and able to anticipate the next step, being superior in strength, leading.

The various types of passivity may befall a person separately or jointly and their traumatic effect varies accordingly. For instance, a tonsillectomy can be a shocking event if the child does not know what to expect—*e.g.*, that he will go to sleep, wake up with pains, be unable to swallow, and so on. If the child has been told about these things beforehand, he

will still be physically inactive and a person much stronger than he will give the orders and inflict pain, yet the shock is likely to be far less severe. The child who has been taken by surprise, who has not had the chance to go over the event beforehand in thought, is more likely to play it out persistently afterwards in an effort at *adjustment and self-cure. Again, play seems to substitute for reasoning.* We can also put it in the short formula: play stands for pre-event anxiety, and anxiety for post-event play.

While the various formulas of play discussed here merge and overlap, certain groupings emerge. There are the play formulas that tell a story and in which several people interact. *Dramatic play,* as it is often called, may be instigated either by the child's wish to be grown-up—presto! And then it seems to say: "It's so hard to wait so long. At least make believe these things." Or possibly: "If I pretend it ardently, maybe it will come true." The rôles the child chooses are pre-stages of identification. Then there are play models based on the opposite formula: "I pretend to be the baby (or clumsy, and so on) in my play; then it's obvious that I am not really clumsy (babyish)." Or: "If I make believe these things, they will not cling to me in real life." The child takes a rôle in order to accentuate the distance between himself and such behavior.

In either case, the child enjoys a gratification denied to him in reality or given in too small a measure. This kind of play helps the child to cope with the frustrations, the fears, the unfulfilled hopes, the disappointments, and the envy rooted in his situation in the family.

Manipulative play and play based on magic are basically different from the above. They are variations and ramifications of body skills and body controls, of oral and anal activities and of the one human relationship that precedes all others—*e.g.,* the infant's need for his mother. They are instigated by his efforts to derive gratifications from his own body or from his mother—not from his broader human environment. With the child's entrance into the Œdipal phase, these play patterns do not disappear, but they lose their prominence.

OBSTINATE CHILDREN ARE ADAPTABLE

KATHARINE M. BANHAM, PH.D.
Duke University, Durham, North Carolina

IT requires more than intelligence to enable a person to do a job successfully, whether this be using a lawn mower or solving an algebraical problem. A feeling of interest and enjoyment in the activity and a desire to have the final product of the work are also required. In other words, whether one be a child or an adult, interest and incentive as well as intelligence are necessary for the learning of new accomplishments or the finding of solutions to age-old problems. One such problem is that of getting along with other people, doing what they want, so as to please them and keep friendly with them, utilizing what limited capacities we have, and at the same time getting enough fun out of life to make it seem worth living.

Children are faced with this problem right after birth—indeed, in a sense, even before birth; and the same social problem recurs again and again throughout life. The child between eighteen months and three years of age, the typical two-year-old, often has a particularly hard struggle with the problem of fitting his wants to those of other people. He gets "cranky" and stubborn or downright rebellious at times. The lanky adolescent youth is another who "will not listen to reason," who does the opposite of what his parents want him to do, or just "moons" around the house in a moody, aimless fashion.

If these observations are correct—that there are times in life and certain situations that make sociable, conforming, and agreeable behavior more difficult than at other times—we may assume that there are reasons why this is so. The existence of science itself is based on the assumption that any observed event is explainable. Sometimes very different reasons may be found to explain the same event. For example, a child of five or six years of age may wet his bed at night because he does not care and has never been trained in bladder control. He sleeps well and does not mind whether his bed

is wet or not. Another child may wet his bed because he cares so much that he becomes frightened at the thought of possible failure. A wet bed to him is uncomfortable and mother's scolding or punishment is even worse. His fear and anxiety cause involuntary evacuation.

With these ideas in mind, let us look at the situation confronting the two-year-old to see whether it will give us a clue to the explanation of the particularly stubborn behavior often noticed at this age. Until the child was over a year in age, he could not get around very well. He stayed in one place, either lying down or sitting up. When he could pull himself to a standing position, he had to hold tightly to something for support. If he let go, he lost his balance and sat down with a bump. But by the time he reached the age of eighteen months, he could go about the room by himself. There were so many more things to do, more things to reach, to handle, to open and look into. In other words, incentives for action multiplied rapidly after the child learned to walk.

All the time that the child had been learning to move about more easily and to go farther, he had been building affectionate attachments with the kind people who had been taking care of him, whether these were parents, grandparents, or foster parents. He had enjoyed doing things to please them, especially when the parents demonstrated their appreciation and affection with smiles, comforting caresses, gifts of food, and other delights. He had ample incentive to be obedient and amenable to their requests.

So long as a child stays in one place, there are not many things he can reach that would cause him harm or that he might damage by rough handling. But once he moves about an ordinary room, not specially prepared for young children, he encounters many things that it may be dangerous for him to pull, push, poke, or throw down. Parents naturally try to stop their children from doing things that would be harmful to them or destructive of property. They scold and sometimes punish their children for actions that are prompted by normal curiosity, but the results of which might be disastrous. The children's power of imagination is not developed sufficiently at the pre-school age for them to envisage the possible dangers. They hear only the scolding or feel the punishment at the hands of the people they have grown to like

and want to obey. The parents' expression of displeasure is connected only vaguely in their minds with what they themselves have done. The reason for the connection, that of potential danger, may not have been apparent to them. They merely resent the punishment, feel offended at the parents, and have less wish to please them.

One result of such an incident may be the experiencing of a new thrill—that of creative activity. The children may have discovered that they can influence their parents' behavior and make them do something different. Their active exploration and meddlesome behavior attracts attention even if it brings scolding in addition. Sometimes this thrill of self-elation due to newly discovered powers becomes an incentive in itself. Children like the attention and excitement they cause.

But this is not always the case, and with some children parental disapproval is too painful ever to have an element of thrill in it. They want affection so badly that fear of forfeiting it frightens them into inaction. A stubborn child may be a frightened child, one who loves so much, wants to please others so much, needs their love so much that he is afraid to act lest his behavior should estrange him more than ever from those he loves. If he is given an opportunity to express his affection in an acceptable way, or if he is shown alternatives from which he can choose the activity that would satisfy his impulsive curiosity and not offend others, he will grow into a coöperative, amenable, and happy child.

The little two-year-old who develops a marked tendency to obstinate behavior may be one who is socially sensitive, attached to the people who care for him and suggestible to their desires and wishes. Such a child is often a model of "good behavior" for a while. He does what he is asked to do, learns quickly or persists conscientiously in trying to do the things that are required of him. This desire to conform or comply with the requests and wishes of others may reach the strength of a compulsion, and sooner or later the child may find himself pressed into doing things to please others that cause extreme discomfort and possible humiliation to himself. It is then that he becomes stubborn. His behavior may take a negativistic turn and he does the opposite of what he is asked to do. It may take the form of open rebellion and outbursts of temper, or it may become generalized inactivity. A tense,

inhibited child is in a state of conflict, wants to go both ways at once, and so stays still, doing neither the thing that pleases him nor what his parents want.

In an article entitled "Some Observations on Contrariness or Negativism" published in MENTAL HYGIENE[1] some years ago, I postulated the theory that some contrary behavior in children may be attributed to the fact that they are hypersuggestible. Their negativistic behavior is a defensive reaction against exploitation by those persons, usually adults, with whom the children are particularly suggestible, pliable, and amenable. The child's behavior is an attempt at adaptation of his own needs as a growing individual and the demands of the people with whom he lives and to whom he is attached.

If this is true, then obstinacy in children may be taken as evidence of growth, of adaptive behavior. The child has distinguished more than one set of demands in his little world. He is trying to respond to them, but he has not yet found an adequate solution that will satisfy all the demands. Following his own interests brings disapprobation, which is not a pleasant incentive. Complying always with the wishes of others does not necessarily satisfy his own interests. Submissive compliance becomes increasingly disagreeable as his thwarted desires grow stronger, and its incentive power diminishes. A thwarted child is in a state of suspended animation. He lacks a pleasant incentive to act. Either he does nothing or his self-interests find expression in the form of negation of social pressures and parental demands.

What has been said of the two-year-old applies equally well to the adolescent who objects to parental regulation or has moody spells of depression or irritability. He is at a special growing point in his life span. He is approaching adulthood, with all its possible freedom of choice and action. The social circle of the growing child has been enlarged to include schoolmates, teachers, employers, club members, and personal friends. A socially sensitive boy or girl wants to have friendly relations with, and be accepted favorably by, all of these persons. Some of them may be similar to his parents in their attitudes and points of view, some will be very dissimilar. The same behavior on the youth's part cannot please all of them.

Before acceptable compromises in behavior are reached,

[1] Vol. 9, pp. 521–28, July, 1925.

adolescent boys or girls may go through periods of contrariness in their behavior, just as the two-year-old child does, and for similar reasons. There is an increase in number of social incentives for the adolescent, a greater variety of things to do, new responsibilities, loyalties, and obligations. There are also stronger urges, due to the physiological changes of puberty and to the development of organized interests and skills. Furthermore, there is a renewed conflict between a feeling of dependence and the need for parental support on the one hand, and on the other hand a desire to launch out into a world full of adventure and to gain independence.

The adolescent's conflict between dependence and independence is similar to that of the two-year-old who has recently learned to perambulate about the house. The small child has a strong need for parental support and help when he gets caught behind the sofa and cannot get out, or when the dog objects to being startled and barks at him. At other times he enjoys making new discoveries by himself. The two-year-old and the adolescent are strongly motivated in more directions than one. In each case the child's behavior alternates. Sometimes he goes to adults for help in doing things that he could do himself or in making decisions and choices. At other times he rejects help and advice and either does nothing or does just the opposite of what is suggested to him. This may be an evidence of resistance against coercion or it may be a beginning attempt to throw off a childish attitude of dependence on adults.

Conflicts between dependent and independent action occur all through life and in all kinds of social situation. They appear to be aggravated during the two periods of childhood that we have mentioned. The increase in number of choices of action, the heightened conflict between the needs for dependent conformity and independent initiative, plus the additional urge for activity present in the ambulatory two-year-old and the adolescent, may account in large measure for the contrariness so noticeable in children at these age periods. Those youngsters who are particularly stubborn may be just the ones who are most sociable and anxious to please. They are not, as the casual observer might think, indifferent to the wishes of others. They are stubborn because they have strong social incentives that are locked in conflict.

A little obstinacy may be regarded as a stage in social adaptation. It is normal behavior and is commonly observed in children at the ambulatory age between eighteen months and three years. It is often apparent also during adolescence. It occurs as a result of conflict and increase in social stimulation. A very dull child, one who is feeble and apathetic, is less likely to show obstinacy in behavior than one who has lively interests and abundant energy. A retarded child, however, may become stubborn in self-protection. The resistive behavior is a defense reaction against social pressure to do things that he is incapable of doing. He is suggestible, sensitive to the social demands and the wishes of others, but is intellectually incapable of solving the dilemma between doing something poorly and humiliating himself or risking disapproval by failure to comply with the adult's requests.

Contra-suggestibility, negativism, and obstinacy in children may be taken as signs of potentiality for good social adjustment. They are forms of behavior that are unsatisfactory in themselves, but that at least show vitality, motivation, and the beginnings of selective sensitivity to a complex social situation. They indicate that the child is capable of developing social and emotional attachments and antagonisms.

A child who is contra-suggestible is also suggestible to social demands within the limits of his capacity and the range of his interests. He is suggestible with those who understand and have sympathy for him. Children become excessively obstinate when demands are made that are impossible for them to execute, when the demands are humiliating, unfair, or exceedingly disagreeable or painful. Obstinate contrariness is a compensatory adaptive reaction, only partially successful, in the interest of self-preservation, growth, and development. It is likely to change to coöperative behavior when the child finds something he can do that will bring satisfaction to him while complying with the wishes of those for whom he cares.

THE USE OF MUSIC AS A THERAPY

HERMINA EISELE BROWNE

Director, Music Therapy Department, New Jersey State Hospital at Marlboro

DOWN through the years, from the beginning of time, man has used music as a therapy, to heal the sick heart and the wounded spirit. When King Saul was restless from the many cares of state, David would be called to play his harp until Saul relaxed and was well again. Hippocrates, the great physician, took his patients to the temple, where there was music, when he could not cure them with medicines. Europe has used music regularly in the rehabilitation of mental patients.

In this country well-known artists presented music in hospitals during World War I, just as they did during World War II, and a few of them made copies and accurate records of the types of program presented and the particular wards or types of patient to whom they were presented, and noted the responses. As a therapy, music is used for the greatest benefit of the patient—to give him not only what he wants, but also what he needs to help him get well, to direct antisocial habits toward socially acceptable behavior, to alter destructive moods, and to guide overactive patients to constructive thinking and activity. The artist's identity is lost, except as the medium through which music is made available. It is, therefore, essential that the therapist know and understand music thoroughly, in order to be able to select suitable music numbers for particular purposes. Rhythmic patterns, tempo, dynamics, harmonies, and melody are most important considerations in selecting music for altering moods and getting active participation responses.

Mrs. Harriet Ayer Seymour, for many years piano teacher at the Henry Street Settlement, New York City, and Willem van de Wall, music educator, were among the first to pioneer in the uses of music in hospitals and institutions in the United States. Having noted the response to it during World War I, they continued their studies and observations after the war was over. Mrs. Seymour, who died in 1944, was organizer of the Foundation for Music Therapy. Dr. van de Wall was selected by the Committee for the Study of Music in Institu-

tions—headed by Dr. Charles W. Tremaine, and Dr. Samuel W. Hamilton, psychiatrist—to make a thorough study of the uses of music in institutions, including mental hospitals.

In 1927, Dr. van de Wall, with the coöperation of Dr. Ira Klopp and Dr. Hamilton, organized a formal program of music therapy at Allentown (Pennsylvania) State Hospital. A year later he brought in Miss Lois Hannaford, a music educator, to take charge of this department, which is still functioning very effectively.

Since then, other hospitals have added music as a departmental activity, but very slowly. The decision to set up a music program was invariably dependent upon finances and upon the medical director's belief in the efficacy of such a program. Music has been used on a hit-or-miss basis in many institutions for some time, being fostered either by volunteers or by the recreational or the occupational-therapy department. But as a planned program with a definite end in view, functioning under the guidance of trained musicians, it is a new venture in our country. World War II restimulated activity along these lines, and since then progress has been made by leaps and bounds, culminating in the formation of the National Association for Music Therapy (1950), which is pledged to progressive development of the use of music in medicine, the advancement of educational and professional standards in music therapy, and the maintainance of a close working alliance and liaison with the medical profession.

Several universities have instituted in their music departments courses for the training of music therapists, in coöperation with medical-school and hospital in-service-training programs. The University of Kansas, the University of Michigan, the Musical Guidance Center for Functional Music (Boston), and the Long Island University are a few of those already well established.

As recently as 1945, when it was my privilege to make surveys of mental hospitals under the guidance of Willem van de Wall and Dr. Samuel W. Hamilton, most physicians declined to accept music as a therapy, primarily because of the lack of scientifically proven data. A few of these physicians who were openminded, or who had the time to go into the matter more thoroughly, were willing to make control-case trials. These experiments, too, were no doubt responsible

for the rapid progress functional music programs have made within recent years. Now the cry is for properly trained personnel and funds and equipment with which to carry on a well-integrated program. The general public has been most hearty in its response to pleas for used equipment, but the supply is not enough to care for the thousands who need and want music in its various forms.

In a very short time the music-therapy department will stand side by side with other therapy departments as a necessary adjunct in the treatment of the mental patient. There will, of course, be some overlapping in the uses of music in the various departments, just as there is overlapping in the uses of food, medication, and activities. It is the close coöperation of departments, always with the aim of helping the patient to become a well-integrated personality, that makes for a well-rounded therapy program.

The music-therapy program at the State Hospital at Marlboro, New Jersey, was instituted by Dr. J. Berkeley Gordon, medical director, and Dr. David Wade McCreight, clinical director, who, in the fall of 1948, brought the writer to the hospital to organize such a department. The department opened officially on December 2, 1948, with one piano, one portable "White" organ—both badly in need of tuning—a few sheets of old popular music, some old records, a bass drum, and a record player that did not work. The best room available was one in the basement of a cottage, a fairly large, airy room with water facilities. Later, other necessary equipment was added, such as benches, a desk, and a cabinet in which to keep music when it arrived.

Twenty-two patients constituted the first group to sing carols on wards and in dining rooms that first Christmas. With the aid of an Antioch College student, a ward program was set up, so that within a given week most of the wards had at least a half-hour's program of music. In due time printed music was secured, and violins, a cello, two saxophones, guitars, and other fretted instruments were forthcoming, through the kindness of friends and an interested public. Later, additional pianos and a supply of records were also donated.

Meantime, we worked with the materials at hand, presenting an informal spring musicale early in 1949. By June we were

ready to present the light opera, *The Pirates of Penzance,* which was a tremendous success from all points of view. Forty-seven patients and three employees took part. All props and scenery were made in our department. The Women's Auxiliary furnished materials and made up the women's costumes under our guidance. The men's costumes were developed from materials available at the hospital. This was not without its humorous side; the "pirates," for instance, were all labeled M.S.H. across the shoulders.

Patients worked with us on the recommendation of the nursing department or of attendants, or by personal request, all being approved by the chief of service before actually taking part in any way. A musician friend came to conduct the performance, leaving the director free to take care of the behind-the-scenes business, and the Elizabeth Musicians' Local 151 furnished several men for the orchestra.

Our leading tenor was a patient classified as dementia praecox, catatonic, with underlying psychopathic personality with pathological sexuality. He was discovered as a possible candidate for the rôle while he was residing on the men's disturbed ward. He always sang with the group and, when approached, expressed a keen desire to have lessons. Permission was obtained from the physician in charge of men's service to teach this man, but he had to be "specialed." He had a high, clear tenor voice. Shortly after he began his music lessons, he was placed on insulin treatments each morning; each afternoon we took him out and began all over again to teach him his part. But each day he remembered just a bit more from the previous day, so that eventually we made progress. This was evidenced in the fact that his voice no longer was a pure tenor, but gradually became heavier in texture and also not quite so high. By the time of production, he was able, by dint of interest and effort, to give an excellent account of himself as tenor lead. Within a few weeks after this performance, however, though he continued to sing regularly with us, he could no longer sing tenor, but began to develop his true baritone voice. Early in the fall he was released on parole; he returned to us in October as a guest to sing for a special musical revue, compiled and dramatized by the director, entitled, *In the Luxembourg Gardens,* at which time he was a definite full-voiced baritone.

Because of the heavy influx of new patients, in April, 1949, we had to turn over our studio to the nursing department to make room for twenty-eight beds, and we were given a room next door which is less than half the size of the first room—in fact, approximately only sixteen feet square—with no washing facilities. Its only recommendation is that it has an outside entrance and is dry. A shower-lavatory room nearby has to be used by both male and female patients; there are no facilities for employees. This was to have been a temporary arrangement, but it appears to be permanent at this writing.

Since the room is too small to accommodate the large group of patients—we now have ninety-six—we received permission to use an open cottage for afternoon rehearsal, which was later rescinded, and we now have morning rehearsals for the large group. The studio is used for small groups and individual work. Plans have been laid for the building of a larger studio in the basement of another cottage, with proper toilet facilities, which will ease our crowded accommodations somewhat.

Our ward programs progressed as per schedule. We added programs to the disturbed buildings twice weekly. Here music has proved to be of the greatest value in that it keeps down combative behavior, eliminates breakage and fights to a certain degree, and releases tensions through emotional outlets along constructive lines. These patients always welcome the therapist, even when they appear to be completely withdrawn. Such a patient, though he took no active part in the music program and appeared not to be listening, has come to us at the close of the music session, and said, "Thank you," occasionally extending his hand to show appreciation.

With the aid of two Antioch College students, we have been able to increase our service to our patients. Ward music programs are selected according to type of ward and the particular mood of patients on that ward. One cottage, for instance, is generally quite active, occasionally noisy. Here we begin with cheerful, lively tempos and sing loudly, paying little attention to those on the ward. Gradually they join us in singing, ask for favorites and repeats. If they wish, we have them sing or play solos. As the mood changes, we play softer and slower music, and by the time we leave, the ward is generally relaxed and happy.

Here is where the attendant or technician can be of great assistance. He can gently urge a patient to participate, or redirect his activity. When there are patients on the ward who like to sing or play, he can encourage them to release pent-up emotions through a stated period of music activity each day by himself or with other patients on the ward. This precludes a patient from monopolizing an instrument, or annoying others on the ward with continual outbursts, yet gives him the activity he craves on an orderly, routine basis. If no music is available, he can call upon the music department, which is only too glad to loan printed music for such a purpose. Also, if he finds that record music is enjoyed and useful, he can borrow equipment, if and when it is available, and have a brief music program daily at a time when the ward is apt to be restless.

The attendant or technician can also be useful and helpful by suggesting names of patients for the chorus, orchestra, individual attention, or study groups to the department head, who in turn will check with the physician for approval. He can also be most helpful by encouraging the patient to attend regular sessions of the ward and helping him to be ready at the appointed hour.

On senile wards strong, rhythmic music is most beneficial because it induces motor responses such as walking about, clapping the hands, tapping the feet, or nodding the head, stimulating the appetite and creating a feeling of general well-being. We frequently use our rhythm instruments here also to induce active participation. Marches, waltzes, folk songs, and lively, familiar hymns with hopeful messages are used most and with the best results. The same holds true in our deteriorated wards. Here we frequently get more vocal participation as well as motor response, but it takes a little longer. In this ward we have several good drummers, a whistler, and a pianist who invariably plays the *St. Louis Blues.* If he can stay at the piano long enough, he will modulate into *Prelude in C# Minor,* return to the *Blues* and back again to the *Prelude,* completing it with a flourish, and then going on to whatever piece may come to his mind. This is a regular procedure. The patient is a very deteriorated case of dementia praecox, hebephrenic, institutionalized since 1934.

Also in this ward is a former excellent musician conductor,

who will play any composition requested, but he never completes a given number, as a change in harmonic pattern recalls another piece and he goes into that one. He will entertain others and himself for long periods of time in this way, never actually completing anything. For this reason one cannot sing with him. He also begins his part of the program by requesting every one to stand while he plays the *Star-Spangled Banner*. In order to keep him from monopolizing the program, we give him a time limit. He readily agrees to this, and when time is up, we ask him to come to a stop, so that others may take part. In this way he is not hurt and every one is satisfied. He always conforms—if we explain first.

Music on tuberculosis wards should be cheerful, soft waltzes and outdoor music. Bed patients always appreciate gay, familiar classics, especially hopeful hymns and folk songs, particularly in their native language. As they cannot participate too much, programs must be well-planned in advance to avoid periods of uncertainty during which the interest of the patient is lost. Reception wards need music that has frequent changes of tempo and mood as well as dynamics and rhythm. For a group of younger persons, popular music is suitable, but for older persons ballads, folk songs, and old-style popular music is best.

We have broadcast programs over the public-address system to various wards with gratifying results from the patient standpoint. However, as our monitor board gets very busy at times, the extra activity proved to be too much for the operator and we have had to discontinue this service until a proper public-address system can be added to our set-up. Occasionally, we present special record music in the patients' dining room while they have supper. Here instrumental numbers are best and such as are not too fast or excitable in tempo or rhythm. Again, care must be taken that the music can be heard without being too loud to be disturbing.

As printed music became available, we were able to plan and prepare additional programs by the chorus and soloists, and within a year had our orchestra and rhythm band well under way. *The Mikado, Epic of America* (an original, historic pageant), and several concerts were added to our repertoire. This last Christmas the chorus was divided into smaller groups with a few instrumentalists in each, and presented

thirty-eight carol programs on wards, in dining rooms, and in the foyer of the main building.

Since Christmas, our program has been considerably curtailed for lack of assistance. Antioch College has had no music students to send, and others have not been forthcoming, though promised in the future. At this writing, a part-time worker, a Juilliard student, has begun his duties and a full-time assistant has been authorized. Now all we need do is to find one capable of doing the required work.

On the whole, these students have been a fine type of worker for institutions, though their youth, coupled with their lack of music training, has been a handicap in our special field. As young people interested in serving humanity, they have been keen and sympathetic. With a permanent, trained assistant, these Antioch students could be very useful in our work. Probably the greatest difficulty lies in the fact that they can stay only from two to three months at a time and are just beginning to be of use when they leave. Only the exceptional student can or cares to return for a second work period. We have, however, had two such fine young students.

Chorus rehearsals are divided into four sections for four-part harmony which patients can learn when properly taught and if the music is not too difficult for their particular group. The type of music is always determined by the educational background and mental ability of the patient. Anthems for Protestant services are not always sung in four-part harmony because they, of necessity, do not receive adequate rehearsals; hence, in these we make the necessary adjustments. For the Catholic services we use the Gregorian hymnary and a portable organ. Special music is always prepared for special holy days. Small groups are used to present programs on wards at stated intervals, to augment the regular ward-participation programs.

In addition to our ward, chorus, orchestra, and rhythm-band programs, we also have music for electro-convulsive-shock therapy, and a music appreciation and study group. Classes in sight-singing and harmony are held when we have patients who are able to absorb such instruction. The music-study group is an outcome of patient request, and the patients themselves prepare the papers on a given subject, guided by the therapist. Interest in these sessions is very keen; discussion

periods are lively and informative. A given composer's life is studied and his work discussed, particularly in relation to other composers of his day, but also in relation to other arts in the same era. Another patient, having prepared certain songs or piano selections, will present them during the discussion period, and we usually end with listening to recordings of sonatas or a symphony.

Whenever possible or advisable, we connect a composer's affliction with his determination to overcome it, bringing out the value of handicaps, disappointment, sorrows and so on as "stepping-stones" to integration and well-being. Time is always too short for these sessions. We believe that by preparing a paper himself, the patient derives greater benefit and it gives him an opportunity to express himself. It also enables the therapist to discover just what his reading abilities are, what materials he expects from the book, and which appeal to him most—trifles or substance.

Music before, during, and after electro-convulsive-shock therapy has been conducted on the disturbed wards since the early summer of 1949 when a record player was made available for that purpose, with sufficient records to carry out a properly prepared program. Before that we had presented music on all three wards of the male and female buildings on an active-participation basis with song sheets and organ. These programs were continued with the addition of the records used in electro-convulsive therapy. Through the efforts of Charles Morris, technician in charge of the male disturbed building, a large radio-record player was purchased, and this building now also has music during meals and at other stated intervals during the day when the music therapist is not there. The opinion of our medical staff of our electro-convulsive-shock program is that "this one use of music therapy justifies the existence of such a department." One physician has on several occasions made the statement: "Music provides the opening wedge which enables us to reach our patient better." At the Medical Center, New York, Rev. Dr. Hartley and Rev. Dr. Russell used to call us in to present emotional music to certain patients just before an intended visit because they found the patient more willing and able to discuss his problem after being conditioned through music.

In our electro-convulsive-therapy programs, we use music

that is familiar and cheerful, but not agitating—relaxing rhythms, semi-classics, while the patients wait, and a slightly stronger rhythm when they begin to wake up. Primitive rhythms are rarely good, as they rouse baser instincts in an emotionally insecure person. Some popular music is used, if melodious. It is interesting to note that patients accept popular music without comment, but when we play light and semi-classics and familiar symphonies, they will ask, "What is it? I like that."

Attendants and technicians have told us that demands by patients for cigarettes, going to the toilet, or just wandering about, are considerably lessened when they have music. Patients themselves make pertinent comments, all on the favorable side of the ledger. Sometimes women patients will sing or dance to this record music. Workers are more cheerful, too. When the sessions have to be temporarily discontinued, as happened recently while the record player was in the repair shop, we are told at the next session that we were missed. During the actual treatment period, volume is kept quite low, so that the shock team can hear instructions as they work; music provides a pleasant undertone.

This department also provides music for picnics, parties, dances, fashion shows, and other programs presented at intervals by volunteer groups or other departments. With adequate and competent assistants, we have individual instruction in voice, piano, and other instrumental work, dependent upon the patient's needs, interests, and abilities.

A manic was assigned to us who was unable to concentrate on any given activity for more than a few minutes at a time. She was referred to us by her physician because of her previous interest in music. We tried her at the piano and found that she could not play more than two or three measures without jumping up to stretch her legs, dance about, request a drink of water or a breath of air. By constant recalling her to the task at hand, we managed after many sessions to get her to stay at the instrument for ten minutes, then longer, until a given piece was completed. Also, she gradually became able to play more accurately and to recognize errors in time, which were more frequent than errors in notes.

In time, we had her play with several other patients in a piano quartette. In this group her overactivity reacted

favorably on an involutional patient and, under our guidance, each was able to help the other through a mutual medium. It took many hours, daily practice, gentle urging, and patience, but results were forthcoming. When our manic found that she could play again, she asked if she might sing, so we worked with her in this medium, helping her to memorize several numbers. She presented the *Habañera* (from *Carmen*) and *Giannina Mia* (from *Firefly*) at our spring musicale and took the audience by storm. Several weeks later she was released from the hospital.

One of our instrumentalists used to spend his time lying on the floor of his ward, coming out only to eat, shave, and for music. A former bank clerk, his appearance and deportment were quite changed from his normal pattern. His one joy was to play the saxophone. He would like to have had an "alto," but since we have none, he plays the "C" melody with equal delight. He reads music, but his rhythmic pattern was much distorted, so we insisted that he play everything as written at first, then let him play in his own style. Now he plays with excellent rhythm both ways. This patient has been in the hospital for some time and with us since early 1949. He is now working in the laundry and very proud of his job.

For community sings, we have printed word sheets, so that all can participate, even in the new songs which are becoming familiar through the medium of television and radio. Fun songs, rounds, and folk songs are alternated with old and new popular melodies and ballads, with constant change of mood and style. Those who like to perform as individuals can have the opportunity on these occasions even though they are not particularly capable. It gives them a chance for emotional release and the satisfaction of having performed in public—which they have always wanted to do—without disrupting a formal program presented by the more able patients.

One patient, aged forty-five years, who was over-shy, retiring, self-deprecatory, and classified as dementia praecox, paranoid, had always wanted to sing, but had not been able to study for lack of funds; also, her very nature precluded her taking part in our activities. Finally she picked up sufficient courage to ask us if she had a chance to learn. We tried her

voice and found it exceedingly guttural, and she had no ear for pitch. However, we told her that we would see what could be done, but that she would have to help herself and be willing to put in much effort and work. This she was. First, we taught her how to listen to tone and reproduce the pitch that she heard. Next came tone-placement and proper breathing. Within three months of four-a-week half-hour sessions she was able to sing an Hungarian folk song as well as any one and she joined the chorus, singing in the alto section. A few months later she was released from the hospital. Through our help she found a sympathetic vocal teacher in her community, joined the local choral society and her church choir, and attended night classes to learn how to sew. We feel that this patient has made an excellent adjustment.

A patient who stuttered considerably came to sing with us and, through private assistance, has been able to overcome somewhat his speech impediment. Another patient who had gone through a lobotomy was inclined to read phrases in a very jumbled manner, sometimes even entirely backwards. We were able to get her to read much better by directing her attention to rhythmic singing, with constant repetition and always correcting even the slightest error. The therapist should at all times be sensitive to mood changes in the patient, should study his needs and try to help him in his thinking when the opportunity arises. Periodic reports are made to the physician in charge of the ward as to the patient's changes in behavior pattern, his interests, participation, and coöperation.

Musicians have volunteered their services and have also been sent by union locals as part of the welfare program through the record-transcription fund. Employees have volunteered to give of their time and talents to assist in our program, all of which is much appreciated. Since the turnover is great, we cannot always rely on such aid. Our department supplies the portable organ and the hymnals for a student nurses' weekly prayer service as well as record music for the mending room, and in general endeavors to coöperate with all departments and their various programs and services.

It is common knowledge that music changes moods even when the patient is entirely oblivious to his present surroundings, though it will take a hostile or very withdrawn personal-

ity somewhat longer to respond to the mood of the music than one who is more amenable. Repetition and the monotony of predetermined rhythm and melody will establish the desired mood. Occasionally well-planned programs do not produce the desired result because of personal associations, forgotten or remembered, with a particular piece, at odds with the general mood of that selection. Hence, it is essential to be aware of reactions at all times and to be prepared to make the necessary changes to more suitable music immediately. As in all other therapies, the aim is to rehabilitate, resocialize, and reëducate a patient through active and passive participation in music. As equipment and personnel are available, we plan to include music with insulin therapy, and to work out an "applied-music" program for specific groups of patients similar in illness and in educational background, who need approximately the same type of treatment for changes in mood or behavior. It is through this type of service with "control cases" that much of our progress in music as a therapy has been made.

While working in a particular hospital for bone diseases, the nurse in charge of a ward stated, "When you come, I might as well throw out the sedatives, for my patients don't need them." It was my custom to present informal, light programs on this ward just before supper and medication time. The patients ate and slept better after these musical evenings.

During my in-service training at Allentown, one patient was assigned to me who was dementia praecox, hebephrenic, had certain compulsive patterns, and was over-religious, religion being the only subject on which he could talk intelligently; all other subjects had no meaning. His music education included choir work, playing the organ, and similar activities. He wanted a Bible, so we secured one for him, and then began our retraining program.

The first day we were introduced, he acknowledged the introduction in the following fashion: "Glad to meet you, Mrs. B—. Sit down. Begin on page one, first line," all the while crossing himself; then he sat down. I acknowledged the introduction and played the first note, and the same ritual began all over again. This kept up until I almost felt like getting up each time with him. However, we finally managed

to get him to sit still for five minutes, then for ten, and later for an entire hour without ritualistic accompaniments. Meantime, we also had to retrain his "ear." Through lack of use, or because of his illness, he had lost his ability to sing a note as he heard it. Patience and complete coöperation from the patient were finally rewarded, and he was able to sing not only notes and words, but with accurate pitch. This man, once an accomplished musician, had to learn to hear tone properly just like any beginner. After several months' work, we felt that we had really accomplished something of value. He was able to join the chorus, hold his own part against the others, and learn other music more quickly than the first selection. During the summer he appeared as soloist in a concert. He had become so well adjusted that when he made an error in the ending of the first chorus section, it did not disconcert him. He covered up the slip, went into the second chorus, and no one, except those who had taught him, knew what had happened. Neither his deportment nor his singing showed that momentary lapse, such as can happen to the finest of musicians when performing from memory.

In order to acquaint the public in general and interested citizens in particular with this modern, yet old, form of therapeutic treatment, we have accepted many calls to speak before civic, church, and educational groups, presenting the work of music therapy as an adjunct to medical and psychiatric treatment in mental hospitals. We are also included in the regular teaching program of student nurses, technicians, and attendants. Despite all the handicaps, we find it most gratifying to know that this field of service is gradually coming into its own.

Through the foresightedness and progressive attitudes of the medico-managerial staff, Marlboro State is the first state hospital in New Jersey to set up a music-therapy department. We are fully aware of the many complexities that arise in developing any type of program in a state institution and we deeply appreciate the whole-hearted support of all concerned, but particularly that given by Dr. David W. McCreight and Dr. J. Berkeley Gordon, medical director of the hospital.

RATES OF DISCHARGE AND RATES OF MORTALITY AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS*

BENJAMIN MALZBERG, PH.D.

New York State Department of Mental Hygiene, Albany

EACH year large numbers of patients are admitted to the New York State hospitals for mental disease. Each year shows an appreciable increase in their number. It is of great importance, therefore, to determine what happens to these patients after admission to the hospitals. As a result of treatment, do they leave the hospitals and return to the community? If they leave, at what rate does this occur? Are the periods of hospitalization short or long? How many die in the hospitals, and during what periods after admission do the deaths occur? Finally, how many of the original admissions remain in the hospitals at the end of stated periods?

To answer these questions, it was determined to trace the histories of patients admitted to the New York civil state hospitals. This was made possible by the introduction of a system of recording on punched cards, and the use of modern tabulating machines. A punched card was prepared for every patient admitted to a state or licensed hospital for mental disease since April 1, 1943. Corresponding punched cards were prepared when the patient was discharged or died. Each time a patient was readmitted, the process of preparing punched cards was repeated. The punched cards are brought together in a permanent file, and arranged in a chronological order for each patient, following the original admission. Thus, it is possible to trace the history of each patient, showing whether he was discharged or died, and after what period of hospitalization this occurred.

When the present investigation was begun, the statistical

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files contained punched cards for every patient admitted between April 1, 1943, and March 31, 1949. Discharges and deaths were also recorded and filed up to March 31, 1949. Thus the history of a patient admitted on April 1, 1943, could be traced up to March 31, 1949, or for a period of six years. On the other hand, a patient admitted on the last day of the fiscal year (*i.e.*, March 31, 1944) could be followed for only five years. Similarly, a patient admitted on the first day of the next fiscal year could be followed for five years, whereas one admitted on the last day of the year could be studied for only four years. Finally, patients admitted during our last fiscal period could be followed from a minimum of one year to a maximum of two years.

The admissions of each fiscal year were followed as separate groups. As it is essential that each member of a group or cohort have the same period of observation (or exposure), it was necessary to follow each patient for a period no greater than the minimum for that group. Thus, since the minimum period of observation for those admitted between April 1, 1943, and March 31, 1944, was five years, it was necessary to make this the maximum for all members of the group, and each patient admitted during this year was followed for a period of five years from the day of admission. The same principle was applied to patients admitted in succeeding fiscal years.

For the purposes of the present investigation, I am reporting the preliminary results for those who were admitted to the New York civil state hospitals during the fiscal year from April 1, 1943, to March 31, 1944. From these admissions, we selected those who were technically first admissions, and from among these first admissions, we made a further selection of those who were treated only in the civil state hospitals. Thus, first admissions who were transferred to or readmitted later to a licensed hospital were excluded from the study. On this basis, we began with a total of 12,655 first admissions, of whom 5,828 were males and 6,827 were females.

The duration of treatment was measured from the date of admission to the hospital to the date of removal from the books, either by discharge or death. No account was taken of time spent in convalescent care (parole). There were two

reasons for this. In the first place, placement in convalescent care is in itself a part of treatment. Patients are examined at intervals in the after-care clinics prior to discharge. Again, many patients placed in convalescent care are returned to the hospital. There may be several subsequent placements in convalescent care before final discharge. Any implication, therefore, that time in convalescent care is not a part of treatment is, in my opinion, unjustified.

In the second place, the use of convalescent care varies from hospital to hospital, being dependent in large part upon the attitude of the responsible medical officer, usually the clinical director. In one hospital the parole rate may be high because the director favors such a policy. In another hospital, under exactly the same circumstances, the parole rate may be low, because the director may fear the possible consequences of adverse publicity if one of his patients should commit a crime. Therefore, if time in convalescent care were excluded from the duration of hospital residence, the same patient would have a longer residence in one hospital than in another, simply as a consequence of varying policies with respect to parole.

Of the 5,828 male first admissions, 2,344, or 40.2 per cent, were discharged within five years after admission to the hospitals. (See Table 1.) The great bulk of the discharges

TABLE 1. PATIENTS DISCHARGED FROM THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

	Males			*Females*		
Period of hospitalization	Number of discharges	Per cent	Rate per 1,000 exposures *	Number of discharges	Per cent	Rate per 1,000 exposures *
First three months..	558	23.8	430.6	449	15.7	288.8
Second three months	142	6.1	147.8	126	4.4	100.6
Third three months..	73	3.1	84.0	58	2.0	50.1
Fourth three months	62	2.6	76.3	63	2.2	57.1
First year	835	35.6	170.6	696	24.4	117.8
Second year	1,171	50.0	374.7	1,708	59.8	414.7
Third year	212	9.0	125.0	286	10.0	134.4
Fourth year	88	3.8	67.4	120	4.2	72.0
Fifth year	38	1.6	34.8	47	1.6	32.9
Total discharges..	2,344	100.0		2,857	100.0	

* On an annual basis.

occurred within two years after admission. Of the 2,344 discharges, only 338, or 14.4 per cent, occurred after the end of the second year of hospitalization. There were 835 discharges during the first year after admission, or 35.6 per cent of the total. Within this period, the first three months proved to be highly significant. Half of the total discharged occurred during the second year of hospitalization. The building up of discharges during this period is a consequence of the expiration of periods of convalescent care (parole) during this interval. It is evident that the chance of discharge declines rapidly after two years of hospitalization.

The highest rate of discharge per 1,000 annual exposures occurred during the first three months after admission. During this period the rate was 430.6 per 1,000. The rate declined rapidly during the first year, reaching 76.3 during the last three months of the year. The average discharge rate for the first year of hospitalization was 170.6. The rate increased to 374.7 during the second year, and then declined rapidly to a minimum of 34.8 during the fifth year.

The female series consists of 6,827 first admissions, of whom 2,857, or 41.8 per cent, were discharged during the period of five years following admission to the hospitals. (See Table 1.) As in the case of the males, the discharges occurred predominantly during the first and second years of hospitalization. Discharges during the first year totaled 696, or 24.4 per cent of the total discharges. This was much less than the corresponding percentage among males. The significant period of discharge during the first year was the first three months, when there were 449 discharges. The discharges decreased very rapidly during the remainder of the first year. During the second year of hospitalization, there were 1,708 discharges, or 59.8 per cent of the total. After the second year there were only 453 discharges, or 15.8 per cent of the total.

During the first three months, the discharge rate per 1,000 annual exposures was 288.8. The rate declined to 57.1 during the last three months of the first year of hospitalization. The average discharge rate for the first year was 117.8 per 1,000 annual exposures, compared with 170.6 among males. During the second year, however, the discharge rate rose to 414.7 per 1,000 among females, compared with only 374.7 among the

males. The discharge rates fell rapidly after the second year, though, in general, they remained in excess of the corresponding rates among males.

The discharge rates varied inversely with the age at first admission. (See Table 2.) Of those aged 30 or less, more than 70 per cent were discharged within the five years following admission. Beyond this age, the discharges decreased steadily until a minimum of 5.2 per cent was reached among those aged 85 or over.

TABLE 2. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FIVE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO AGE AT ADMISSION

	Males			*Females*		
	Number of first admissions*	Discharged		Number of first admissions*	Discharged	
Age (years)		Number	Per cent		Number	Per cent
Under 15	92	67	72.8	43	32	74.4
15–19	251	190	75.7	226	165	73.0
20–24	293	211	72.0	388	285	73.5
25–29	318	222	69.8	477	348	73.0
30–34	318	228	71.7	487	346	71.0
35–39	378	233	61.6	445	293	65.8
40–44	411	239	58.2	448	286	63.8
45–49	364	199	54.7	514	280	54.5
50–54	399	193	48.4	484	249	51.4
55–59	443	180	40.6	412	161	39.1
60–64	456	123	27.0	429	131	30.5
65–69	468	102	21.8	499	111	22.2
70–74	557	75	13.4	628	76	12.1
75–79	512	46	9.0	566	52	9.2
80-84	339	23	6.8	461	19	4.1
85 or over ...	211	11	5.2	286	15	5.2
Unascertained	18	2	....	34	8	....
Total.....	5,828	2,344	40.2	6,827	2,857	41.8

* Number of first admissions during the year ended March 31, 1944.

There is a similar inverse relation between rate of discharge and the estimated duration of the mental disease prior to admission to the hospital. (See Table 3.) Obviously, these estimates are not as reliable as statements of chronological age, and, therefore, we cannot expect the same kind of regularity in trend. Nevertheless, it is evident that those with short durations prior to hospitalization have higher discharge

TABLE 3. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FIVE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO THE DURATION OF MENTAL DISORDER BEFORE ADMISSION

Duration of mental disorder before admission	*Males*			*Females*		
	Number of first admissions*	Discharged		Number of first admissions*	Discharged	
		Number	Per cent		Number	Per cent
Less than 1 month	825	444	53.8	786	438	55.7
1–3 months	1,310	590	45.0	1,751	960	54.8
4–6 months	522	228	43.7	674	339	50.3
7–11 months	227	109	48.0	297	130	43.8
1 year	487	158	32.4	667	224	33.6
2 years	311	90	28.9	441	117	26.5
3 years	204	69	33.8	225	67	29.8
4 years	80	23	28.8	165	51	30.9
5 years	114	27	23.7	160	24	15.0
6–9 years	129	40	31.0	242	58	24.0
10 years or over..	129	56	43.4	208	56	26.9
Unascertained	1,490	510	....	1,211	393	....
Total.....	5,828	2,344	40.2	6,827	2,857	41.8

* Number of first admissions during the year ended March 31, 1944.

rates than those with long durations. Among those with short durations (*i.e.*, less than one year), the discharges within five years represented almost 50 per cent of the total first admissions. As the prior duration increased up to five years, the percentage of discharges decreased, falling to 23.7 among males, and to 15.0 among females. Among both males and females, the percentages of discharges increased among those with prior durations of six or more years, though the percentages were less than those with relatively short histories. If this should prove to be a true shift, it may be due to a further correlation between prior duration and types of mental disorder.

Mortality.—Of the 5,828 male first admissions, 2,526, or 43.3 per cent, died during the five years following admission. (See Table 4.) The first three months were the crucial period. During this interval, there were 1,286 deaths, or 50.9 per cent of the total deaths. There was a rapid drop thereafter. During the final quarter of the first year there were only 128 deaths, or 5.1 per cent of the total deaths. During the entire first year after admission there were 1,868 deaths, or 74.0 per

TABLE 4. PATIENTS DYING IN THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	*Males*			*Females*		
	Number of deaths	Per cent	Rate per 1,000 exposures *	Number of deaths	Per cent	Rate per 1,000 exposures *
First three months..	1,286	50.9	927.0	1,216	46.0	736.7
Second three months	281	11.1	287.2	309	11.7	242.4
Third three months..	173	6.9	196.3	196	7.4	166.9
Fourth three months	128	5.1	155.9	120	4.6	108.1
First year	1,868	74.0	345.3	1,841	69.7	284.1
Second year	258	10.2	101.6	343	13.0	99.8
Third year	178	7.0	111.9	221	8.4	105.4
Fourth year	127	5.0	100.6	129	4.9	77.2
Fifth year	95	3.8	88.6	108	4.1	74.0
Total deaths....	2,526	100.0		2,642	100.0	

* On an annual basis.

cent of the total. During the second year the deaths dropped to 258, or 10.2 per cent. The deaths decreased to a minimum of 95, or 3.8 per cent, during the fifth year.

The death rate declined from 345.3 per 1,000 annual exposures during the first year of hospitalization to a minimum of 88.6 during the fifth year. The first three months were decisive, for during this period the death rate (on an annual basis) was 927.0 per thousand exposures. Fortunately, such a rate was not continued. During the second quarter of the first year, the death rate (on an annual basis) fell to 287.2 per 1,000, and was reduced still further during the final quarter to 155.9. The death rate, which was 345.3 during the first year of hospitalization, dropped to 101.6 during the second year, and to 88.6 during the fifth year.

Among the 6,827 female first admissions, there were 2,642 deaths during the five years following admission, or 38.7 per cent, compared with 43.3 per cent among the males. (See Table 4.) The first year was crucial, there being 1,841 deaths during this period, or 69.7 per cent of the total. Within the first year, the first three months again were decisive, 1,216 deaths, or 46.0 per cent of the total, occurring during this period. The death rate (on an annual basis) was 736.7 per 1,000 exposures during the first three months. The death rate fell rapidly to 108.1 during the final quarter. The average

death rate during the first year after hospitalization was 284.1. This dropped rapidly to 99.8 during the second year. The downward trend continued during the following years, with a minimum of 74.0 during the fifth year. In each period of hospitalization, females had lower death rates than males.

There is a correlation between the death rate and the age at first admission. (See Table 5.) Of the male first admissions aged 24 or less, about 3 per cent died during the five years after admission. Of those aged 40 to 49, 20.9 per cent died during this period. Of those aged 50 to 59, 37.8 per cent died. Of those aged 75 or over, almost 90 per cent died.

TABLE 5. DEATHS AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FIVE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO AGE AT ADMISSION

	Males			*Females*		
Age (years)	Number of first admissions*	Deaths		Number of first admissions*	Deaths	
		Number	Per cent		Number	Per cent
Under 15	92	3	3.3	43	2	4.7
15–19	251	7	2.8	226	4	1.8
20–24	293	9	3.1	388	15	3.9
25–29	318	15	4.7	477	25	5.2
30–34	318	23	7.2	487	35	7.2
35–39	378	54	14.3	445	31	7.0
40–44	411	86	20.9	448	52	11.6
45–49	364	76	20.9	514	89	17.3
50–54	399	123	30.8	484	112	23.1
55–59	443	195	44.0	412	154	37.4
60–64	456	251	55.0	429	210	49.0
65–69	468	300	64.1	499	304	60.9
70–74	557	433	77.7	628	460	73.2
75–79	512	443	86.5	566	466	82.3
80–84	339	301	88.8	461	409	88.7
85 or over....	211	195	92.4	286	254	88.8
Unascertained	18	12	....	34	20	....
Total....	5,828	2,526	43.4	6,827	2,642	38.7

* Number of first admissions during the year ended March 31, 1944.

Among the females, the death rates also increased with advancing age. Among the younger first admissions the deaths constituted approximately 4 per cent of the total admissions. This increased steadily until the deaths included almost 90 per cent of the total admissions at advanced ages.

There were 2,884 male first admissions with a history of mental disease of less than a year before admission to a hospital. Of this total, 1,072, or 37.2 per cent, died during the five years following admission. (See Table 6.) The percentage rose, with minor fluctuations, to 60.5 per cent among those with a prior history of five years. The proportion of deaths fell among those with a prior duration of six years or more, but was still in excess of the percentage among those groups with short histories.

TABLE 6. DEATHS AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, WITHIN FIVE YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO THE DURATION OF THE MENTAL DISORDER BEFORE ADMISSION

	Males			*Females*		
Duration of mental disorder before admission	Number of first admissions*	Deaths		Number of first admissions*	Deaths	
		Number	Per cent		Number	Per cent
Less than 1 month	825	275	33.3	786	240	30.5
1–3 months	1,310	518	39.5	1,751	520	29.7
4–6 months	522	199	38.1	674	217	32.2
7–11 months	227	80	35.2	297	111	37.4
1 year	487	253	52.0	667	286	42.9
2 years	311	172	55.3	441	226	51.2
3 years	204	100	49.0	225	117	52.0
4 years	80	41	51.3	165	76	46.1
5 years	114	69	60.5	160	95	59.4
6–9 years	129	56	43.4	242	111	45.9
10 years or over ..	129	40	31.0	208	81	38.9
Unascertained	1,490	723	....	1,211	562	....
Total.....	5,828	2,526	43.4	6,827	2,642	38.7

* Number of first admissions during the year ended March 31, 1944.

Females also showed a rising trend in the proportion of deaths, as the duration of the disease prior to hospitalization increased. (See Table 6.) Beginning with a mortality of 31.0 per cent among those with a prior history of less than a year, there was an upward trend to a maximum of 59.4 per cent among those with a history of five years. The mortality decreased among those with a previous history of six or more years, but it remained higher than the proportions among those with relatively short durations.

Table 7 traces the history of the 5,828 male first admissions and 6,827 female first admissions from the date of admission

TABLE 7. NUMBER OF PATIENTS REMAINING ON THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS AT THE END OF SPECIFIC PERIODS AFTER FIRST ADMISSION

	Males		*Females*	
End of	Number	Per cent of total first admissions	Number	Per cent of total first admissions
Third month	4,006	68.7	5,182	75.9
Sixth month	3,596	61.7	4,759	69.7
Ninth month	3,361	57.7	4,521	66.2
First year	3,177	54.5	4,338	63.5
Second year	1,801	30.9	2,383	34.9
Third year	1,478	25.4	1,954	28.6
Fourth year	1,286	22.1	1,753	25.7
Fifth year	1,182	20.3	1,657	24.3

to the end of five years of hospitalization, and shows the number remaining on the books of the hospitals after stated periods. Those remaining include patients who were discharged after first admission, but who were readmitted subsequently. Thus, after three months, 4,006 males were still on the books of the hospitals, representing 68.7 per cent of the original admissions. By the end of the first year, 3,177, or 54.5 per cent, were still on the books. In a little over a year, half of the total admissions had either died or been discharged. The reduction continued during the second year of hospitalization, though at a slower rate. At the end of the second year, 1,801, or 30.9 per cent, were still on the books. Because both discharge and death rates decreased with years of hospitalization, the process of reduction slowed considerably after the second year. At the end of five years, 1,182 males, or 20.3 per cent, still remained on the books.

There were relatively more females than males on the books at the end of corresponding periods. Thus, at the end of the first year, 63.5 per cent of the females were still on the books, compared with 54.5 per cent of the males. At the end of the second year, there was a rapid reduction among females to 34.9 per cent of the original total, compared with 30.9 per cent for the males. At the end of five years, females included only 24.3 per cent of the original total, compared with 20.3 per cent of the males.

It was shown that discharge rates decline with advancing age, and that mortality rates increase. This is due very

largely to the fact that types of mental disorders are related to age, so that the younger first admissions include large proportions of dementia praecox, and the older patients include the seniles and arteriosclerotics. The observed trends of discharge and mortality for all patients are an average, and conceal important differences. Therefore, I shall consider separately the outcome of hospitalization for groups of first admissions with dementia praecox and psychoses with cerebral arteriosclerosis.

There were 1,189 male first admissions with dementia praecox during the fiscal year ended March 31, 1944. Of this total, 751, or 63.2 per cent, were discharged within five years after admission. (See Table 8.) This is in marked excess

TABLE 8. PATIENTS WITH DEMENTIA PRAECOX DISCHARGED FROM THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

Period of hospitalization	*Males*			*Females*		
	Number of discharges	Per cent	Rate per 1,000 exposures*	Number of discharges	Per cent	Rate per 1,000 exposures*
First three months..	96	12.8	326.0	104	9.9	250.9
Second three months	42	5.6	157.4	51	4.8	132.9
Third three months..	21	2.8	82.5	21	2.0	56.8
Fourth three months	18	2.4	72.5	17	1.6	46.8
First year	177	23.6	151.3	193	18.3	116.9
Second year	423	56.3	437.4	656	62.4	459.2
Third year	94	12.5	179.2	122	11.6	160.5
Fourth year	35	4.7	81.4	57	5.4	90.6
Fifth year	22	2.9	57.2	24	2.3	42.4
Total discharges..	751	100.0		1,052	100.0	

* On an annual basis.

over the corresponding percentage (40.2) for all first admissions. The discharge rate per 1,000 annual exposures was 151.3 during the first year after admission, and 437.4 during the second year. The discharge rate was relatively low during the first year, but was high during the second year. The discharge rates dropped rapidly after the second year, but were higher than those for the entire cohort of first admissions.

There were 1,751 female first admissions with dementia praecox, of whom 1,052, or 60.1 per cent, were discharged

during the five-year period of exposure. This was almost 50 per cent in excess of the corresponding discharge rate for all female first admissions. The rate of discharge per 1,000 annual exposures was highest during the second year after admission, when it was 459.2. During each successive year of hospitalization the discharge rate dropped, but remained higher than the corresponding rates for all female first admissions.

If the discharge rates for both males and females with dementia praecox were above the average, it is clear that their death rates were correspondingly low. Thus, of the 5,828 total male first admissions, 2,526, or 43.3 per cent, died during the five years of observation. Among the 1,189 male first admissions with dementia praecox, only 79, or 6.6 per cent, died during this period. (See Table 9.) Among all male first admissions, there was a heavy mortality of 927.0 per 1,000 annual exposures during the first three months after hospitalization. In the case of dementia praecox, it was only 77.1. During the first year, the rate was 345.3 for all male patients, but only 35.4 for male dementia-praecox patients. During the second year the death rate fell to 15.8 per 1,000 annual exposures among first admissions with dementia praecox, and continued low in the remaining years.

TABLE 9. PATIENTS WITH DEMENTIA PRAECOX DYING IN THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

	Males			*Females*		
Period of hospitalization	Number of deaths	Per cent	Rate per 1,000 exposures*	Number of deaths	Per cent	Rate per 1,000 exposures*
First three months..	22	27.8	77.1	34	39.1	83.8
Second three months..	8	10.1	30.4	5	5.8	13.2
Third three months..	6	7.6	23.8	3	3.4	8.2
Fourth three months..	3	3.8	12.2	6	6.9	16.6
First year	39	49.4	35.4	48	55.2	30.4
Second year	12	15.2	15.8	11	12.6	9.9
Third year	7	8.9	14.3	14	16.1	19.8
Fourth year	14	17.7	33.4	4	4.6	6.7
Fifth year	7	8.9	18.6	10	11.5	17.9
Total deaths.....	79	100.0		87	100.0	

* On an annual basis.

Among female first admissions with dementia praecox, there were 87 deaths within five years after admission, or 5.0 per cent of the total first admissions. (See Table 9.) This may be compared with 38.7 per cent among all female first admissions. Female first admissions with dementia praecox had, in general, lower death rates than the males. They had a death rate of 83.8 per 1,000 annual exposures during the first three months after admission, but the average for the first year was 30.4, compared with 35.4 for the males, and 284.1 for all female first admissions. The mortality dropped to very low levels after the first year.

Primarily as a consequence of the low rates of mortality, the number of patients with dementia praecox remaining on the books at the close of stated periods was relatively high. Thus, of all male first admissions, 54.5 per cent were on the books at the end of the first year of hospitalization, but the corresponding percentage for males with dementia praecox was 83.4. (See Table 10.) At the end of the second year, the percentages for all male patients and for male dementia-praecox patients were 30.9 and 49.7, respectively. By the end of the fifth year, 40.4 per cent of the group with dementia praecox were still on the books, compared with only 20.3 per cent of all first admissions.

TABLE 10. NUMBER OF PATIENTS WITH DEMENTIA PRAECOX REMAINING ON THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS AT THE END OF SPECIFIC PERIODS AFTER FIRST ADMISSION

	Males		*Females*	
End of	Number	Per cent of total first admissions	Number	Per cent of total first admissions
Third month	1,078	90.7	1,623	92.7
Sixth month	1,034	87.0	1,569	89.6
Ninth month	1,010	84.9	1,551	88.6
First year	992	83.4	1,530	87.4
Second year	591	49.7	915	52.3
Third year	525	44.2	836	47.7
Fourth year	484	40.7	803	45.9
Fifth year	481	40.4	811	46.3

A similar trend was shown by the females with dementia praecox. At the end of the first year, 87.4 per cent of the females were still on the books. (See Table 10.) This dropped almost in half by the end of the second year, to 52.3

per cent, but decreased slowly thereafter to 46.3 per cent at the end of the fifth year. The corresponding percentage for all female first admissions was only 24.3 per cent.

The experience of the first admissions with psychoses with cerebral arteriosclerosis stands in sharp contrast to that of admissions with dementia praecox. There were 1,540 male first admissions with psychoses with cerebral arteriosclerosis, of whom only 262, or 17.0 per cent, were discharged within five years after admission. (See Table 11.) This may be contrasted with corresponding percentages of 40.2 for all male first admissions, and 63.2 for male dementia-praecox patients. The discharge rate per 1,000 annual exposures was 80.7 during the first year of residence. It rose to 234.5 during the second year, but fell rapidly to 5.4 during the fifth year.

TABLE 11. PATIENTS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS DISCHARGED FROM THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

	Males			*Females*		
Period of hospitalization	Number of discharges	Per cent	Rate per 1,000 exposures*	Number of discharges	Per cent	Rate per 1,000 exposures*
First three months ..	62	23.7	99.6	52	17.7	159.9
Second three months	9	3.4	21.5	9	3.1	38.4
Third three months..	11	4.2	29.8	5	1.7	24.3
Fourth three months..	9	3.4	27.2	10	3.4	53.1
First year	91	34.7	80.7	76	25.9	64.7
Second year	134	51.1	234.5	188	64.2	286.8
Third year	22	8.4	64.7	21	7.2	58.1
Fourth year	14	5.3	50.9	6	2.0	21.8
Fifth year	1	0.4	5.4	2	0.7	9.2
Total discharges..	262	100.0		293	100.0	

* On an annual basis.

Of the 1,550 female first admissions with psychoses with cerebral arteriosclerosis, only 293, or 18.9 per cent, were discharged within five years (see Table 11), compared with 41.8 per cent of all female first admissions, and 60.1 per cent of female dementia-praecox patients. The discharge rate rose from 64.7 per 1,000 annual exposures during the first year to 286.8 during the second year, but fell rapidly to 9.2 during the fifth year.

If the discharge rates were low among first admissions with psychoses with cerebral arteriosclerosis, the death rates were high. (See Table 12.) Thus, of the 1,540 male first admissions, 1,118, or 72.6 per cent, died within five years after admission. This may be compared with 43.3 per cent among all male first admissions and 6.6 per cent among male patients with dementia praecox. The death rate was 551.4 per 1,000 annual exposures during the first year after admission. If the rate of mortality during the first three months had continued, all of the arteriosclerotic group would have died within six months after admission. However, the death rate dropped after the first three months, fell to 191.8 during the second year, and rose only slightly during the next three years.

TABLE 12. PATIENTS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS DYING IN THE NEW YORK CIVIL STATE HOSPITALS, CLASSIFIED ACCORDING TO PERIOD OF HOSPITALIZATION AFTER FIRST ADMISSION

	Males			*Females*		
Period of hospitalization	Number of deaths	Per cent	Rate per 1,000 exposures*	Number of deaths	Per cent	Rate per 1,000 exposures*
First three months..	590	52.8	(1000.0)	499	46.9	(1000.0)
Second three months	103	9.2	466.3	126	11.8	506.8
Third three months..	74	6.6	384.2	83	7.8	385.4
Fourth-three months	57	5.1	332.1	44	4.1	228.3
First year	824	73.7	551.4	752	70.6	497.4
Second year	107	9.6	191.8	133	12.4	211.8
Third year	88	7.9	235.9	79	7.4	202.3
Fourth year	56	5.0	209.7	52	4.9	174.4
Fifth year .....;	43	3.8	211.3	49	4.6	202.4
Total deaths....	1,118	100.0		1,065	100.0	

* On an annual basis.

Female first admissions with psychoses with cerebral arteriosclerosis also had a high death rate. (See Table 12.) Of the 1,550 first admissions, 1,065, or 68.7 per cent, died within five years after admission. Of all the female first admissions, 38.7 died during the same period. Of the female first admissions with dementia praecox, only 5.0 per cent died during this period. As in the case of the males, there was an exceedingly heavy rate of mortality during the first three months of hospitalization. The death rate for the first year

was 497.4 per 1,000 annual exposures. The rate fell to 211.8 during the second year and remained close to this level during the remaining years of hospitalization.

As a result of the high death rates, those remaining on the books at the end of specified periods decreased rapidly. (See Table 13.) Thus, by the end of the first year after admission,

TABLE 13. NUMBER OF PATIENTS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS REMAINING ON THE BOOKS OF THE NEW YORK CIVIL STATE HOSPITALS AT THE END OF SPECIFIC PERIODS AFTER FIRST ADMISSION

	Males		*Females*	
End of	Number	Per cent of total first admissions	Number	Per cent of total first admissions
Third month	890	57.8	1,003	64.7
Sixth month	780	50.6	870	56.1
Ninth month	696	45.2	784	50.6
First year	633	41.1	728	47.0
Second year	400	26.0	410	26.4
Third year	287	18.6	316	20.4
Fourth year	220	14.3	256	16.5
Fifth year	176	11.4	207	13.4

only 41.1 per cent of the males with psychoses with cerebral arteriosclerosis were on the books. By the end of the second year, this was reduced still further to 26.0 per cent. At the end of the fifth year, there were only 11.4 per cent. Among the females, there were 47.0 per cent on the books at the end of the first year, 26.4 per cent at the end of the second year, and 13.4 per cent at the end of the fifth year. In contrast, the corresponding percentages at the end of five years for first admissions with dementia praecox were 40.4 for males and 46.3 for females.

SUMMARY

This paper represents a preliminary analysis of the histories of 12,655 first admissions to the New York civil state hospitals during the fiscal year ended March 31, 1944. Similar analyses are being made of the first admissions during each of the following four years. Each will, therefore, serve as an experimental group, whose experience will serve as a check upon the others. In the final analysis, however, all of the yearly groups of first admissions will be combined to form

one population of approximately 60,000 first admissions, a total that will form a solid basis for establishing stable rates of discharge and of mortality.

The rates derived from these studies will serve a variety of purposes. In the first place, they will give a definite picture of the rate at which any annual group of admissions will be reduced, and will, therefore, make possible the prediction of trends in hospital populations. In the second place, they will serve as norms, against which to measure the results of any new form of therapy. Finally, they will enable us to answer specific questions with respect to expectations of discharge or of mortality. It will then be possible to state that a patient of given sex and age, with a specified diagnosis, will have an expectation of so many years of hospital life after admission, or that his expectation of life will be a certain number of years. These are all questions of nice theoretical interest, but I am certain that the answers will prove of great value to the practical hospital administrator.

THE MENTAL HEALTH OF THE THREE LITTLE MONKEYS*

WALTER W. ARGOW

Executive Director, Indiana Mental Hygiene Society, Indianapolis

OCCASIONALLY one finds on the bric-a-brac shelves of American homes an object known as "The Three Little Monkeys." Done in anything from clay to ivory, it symbolizes what have been regarded as the three outstanding virtues of man. Each monkey in his own way attempts to render himself impervious to evil—one by clapping his paws over his eyes to *see* no evil; another, over his ears to *hear* no evil; and the third, over his mouth, to *speak* no evil.

To-day these little figures have a new significance. It requires no stretch of the imagination for us to see what they symbolize in iron-curtained areas; for in such lands, the mouths of the people are closed by the hand of censorship; the ears of the people are stopped with controlled propaganda; and the eyes are blinded to all except that which the state permits them to see. We pity people who are thus benighted and deprived of the liberty of their senses. We, who are relatively free, wish that there were something we could do to help them cast off the shackles from their eyes, ears, and mouths. We are abetted in our desire to destroy these shackles by a fear of our own—a fear born of knowledge that a people thus deprived of information are dangerous, not only to themselves, but to the world at large. Thus it is well that we bend our energies toward ending this oppression.

But in our zeal perhaps we overlook another and even more serious aspect of the situation—an aspect that a closer look at the three little monkeys brings now to our attention. In dictator states, it is the hand of the *state* that is over the mouth, the hand of the *state* that is over the ears and the eyes, but in the figurine, the paws of the little monkeys *themselves* block their ears and eyes and mouths. When a people will-

* Presented before the Indiana Association of Deans and Women's Advisors, Muncie, Indiana, April 5, 1950.

ingly close their eyes and minds, their integrity and their mental health have indeed degenerated. So it is with the individual; for an individual who shuts out many sense perceptions thus surrenders a kind of freedom and sometimes paves the way for mental illness. Thus, the three little monkeys may be regarded as symbols of people who have given up or who have lost the power of self-discrimination and control and have instead closed a door on their avenues of perception and expression. He who has voluntarily surrendered liberty or personal integrity is in a far sadder state than he who has been deprived of it. Of even greater concern are those individuals who have never exercised freedom of expression.

It troubles me to note that the major interest of many of the persons to whom I talk regarding mental-health problems is in the mentally ill, more particularly those in state hospitals. Serious though the problem of the inmates of these institutions is, we have a far greater problem in the recognition and care of those who are not institutionalized. The budding science of psychiatry is doing all it can for those who are hospitalized, but precious little is being done for those on the border line.

For the moment, therefore, I want to draw attention to the problem of the prevention of emotional maladjustment, for it seems to me that on all sides to-day there is a reckless sowing of the germs of emotional conflict. It is as if there were a kind of bacteriological warfare under way for the minds of men. It goes on before us and we seem indifferent. Perhaps this is because we don't realize what is happening. Instead of providing in our society, through homes and schools and the other forces of education, the tools for nurturing and maturing human personalities, we often actually inhibit this growth. It is one thing to attempt to counteract this ideological warfare through repression and censorship, and it is quite another to control it by developing in people's minds an ability to evaluate information and experiences. In a democratic society the latter is obviously the desirable choice.

The American school system can be thought of as the pride of our times. The teachers, who are the bone, muscle, and backbone of the system, have come up through a long expe-

rience of special training and self-discipline to be the acknowledged leaders of this institution essential to our social order. Yet, with all these positive and efficient resources for intellectual development, there is still a great lack; for it has become apparent, through recent studies, as well as through our own superficial observations, that in all too few places is the planning of the educative process molded around a realistic understanding of the mechanisms of human personality development. In all too few places is there an honest dedication to that needed ingredient in the life of any culture—namely, the development of the effective and independent personality. It is as if we had become enamored of the mechanics of teaching—to the extent of forgetting its purpose.

Admittedly, this has made for progress and has enabled us to bring learning to a large portion of the population, but what have we lost in the meantime? By hastening to provide for the masses, we have become calloused to the fact that each one of the integers in the collective group known as "the masses" is an individual, and that his needs, though similar in many ways to those of his fellows, are still distinct and variable and individualistic. In our haste to do the job, we have often contented ourselves with formalistic criteria of achievement. We have served our students in response to the immediacy of the need rather than with a regard for the patterns of their lives. Have we filled minds—but weakened personalities? Are these pupils seeing only what we show them? Can they hear only what we tell them? Can they speak only what they have heard? Have we helped them to become full-functioning individuals whose personalities are emotionally mature and whose minds are active?

Now, what is this emotional maturity? The best definition that I have found is compiled by two psychiatrists—Drs. Strecker and Appel:

> "Maturity is a quality of personality that is made up of a number of elements. It is stick-to-it-iveness, the ability to stick to a job—to work on it and to struggle through until it is finished, or until one has given all that one has in the endeavor. It is the quality or capacity of giving more than is asked or required, in a given situation. It is this characteristic that enables others to count on one. Thus, it is reliability. Persistence is an aspect of maturity. Persistence to carry out a goal in the face of difficulty. Endurance of difficulties, unpleasantness, discomfort, frustration, and hardship are all included. The ability to size things up

> . . . make one's own decision . . . is a characteristic of maturity. This implies a considerable amount of independence. A mature person is not dependent unless ill. Maturity includes determination. A will to achieve and succeed, will to life. Of course maturity represents the capacity to coöperate . . . to work with others . . . to work in an organization and under authority. A mature person is flexible . . . can defer to time, persons, and circumstances. He can show tolerance. He can be patient; and above all, he has the qualities of adaptability and compromise. Basically, maturity represents a wholesome amalgamation of two things (1) dissatisfaction with the status quo, which calls forth aggressive, constructive effort, and (2) social concern and devotion."

Obviously, this definition is too complex, too detailed, to be digested here at first recounting. It can, however, be epitomized by the symbol which I chose as the subject of my remarks—the three little monkeys—in reverse, for a mature person has his hands *off* his eyes and mouth and ears. Thus he has vision and some imagination. There are no neurotic brakes on his ability to think for himself. There are no optical illusions in his perceptions, occasioned by the mental sickness of ironbound ideas.

The mature person is free to express himself and has developed a healthy forthrightness. When his mind perceives iniquity, he is free to rebel against it and to express his rebellion. His is the mouth that speaks with a quiet self-assurance—an assurance that is not to be confused with a neurotic compensatory aggressiveness.

The mature person has judiciousness and comprehension. He can receive impressions and comprehend them clearly. The information he takes in is not colored by the impression he *wants* to gain. On his intellectual scale, all tones are audible and the information reaches his mind with a minimum of distortion.

This is the kind of person I believe we should be seeking to develop through our teaching efforts. We are dealing with individual minds whose plasticity is as terrifying as it is challenging.

Living as we are in the adolescence of a wondering world, we must awaken to the importance of developing maturity. John H. Dietrich has given a charge to the future of religion which we well might translate to education. He says:

> "If religion is to endure, not as a survival of ancient customs, but as a living force in the development of society, it must be free from the

> superstitions that are today strangling its very life. It must be interpreted anew, in terms of work . . . in service among men."

Translated to the world of learning, this is a call to us to have the courage to break with the formalistic ways of doing our jobs, and of developing within ourselves, as well as within our students, the ability to think independently, and the courage to carry thoughts forward into action.

In his outstanding lecture series on "The Psychiatry of Enduring Peace and Social Progress," Dr. G. Brock Chisholm, Director General of the World Health Organization, has made the statement:

> "Intelligence, ability to observe and to reason clearly, and to reach and implement decisions appropriate to the real situation in which he finds himself, are man's only specific methods of survival. His unique equipment is entirely in the superior lobes of his brain. His destiny must lie in the direction indicated by his equipment. Whatever hampers or distorts man's clear, true thinking works against man's manifest destiny and tends to destroy him. Man's freedom to observe and to think freely is as essential to his survival as are the specific methods of survival of the other species to them. Birds must fly; fish must swim; herebivorous animals must eat grasses and cereals; and man must observe and think freely."

It would be both impossible and fruitless for me to attempt to discuss in any detail the various ways in which this point of view can be applied to the teaching process. We need no recipe for the development of intellectual and emotional maturity that can be assembled and followed in detail.

Returning to the illustration of the three little monkeys, it is our job not only to refrain from inhibiting a developing mind, but, even further, to aid our students in every way to resist this intrusion on their rights by any one and to build up within them a resistance to any poison that would rob them of their will to grow to emotional adulthood. Similarly must we resist any effort to repress arbitrarily the expression of a rebellious spirit and should, instead, view this rebelliousness as the symbol of the frantic effort of the personality to achieve individuality. As teachers and leaders, perhaps you will be the target of much misplaced hostility, for on all sides to-day there are forces that seek to cramp, distort, and mold men's personalities. The individual, if he is not emotionally sick, will tend to respond to this coercion with

aggression. Perhaps he cannot express this aggression in the home, and, instead, it will come out elsewhere.

It is the basic aim of education to help make the individual intellectually self-sustaining and independent. We must likewise include in our effort the development of emotional independence, for here lie the roots of resistance to coercion. If we are to develop citizens of stature, then we must help them fight against the brakes on their expression. This does not mean the development of license, for the emotionally well personality is one who is also aware of the rights of others.

The three little monkeys were sick little monkeys—an anachronism. They are relics of an age that put its faith in willful self-censorship, symbolically as well as actually. The successful personalities who lived in this age relied for successful living on the splints provided by rigid formalism, and when the splints were removed or broken, the individual was helpless, for he had not developed his intellectual and emotional muscle. Thus he became prey to his own institutional leaders and controlled by a frightening dread of his own inadequacy. Through the material progress made possible by our scientists, we are now living at a time when the individual must be more self-reliant. Though man is still part of the group and always will be, the trend is increasingly in the direction of a broadening democracy. This gives him more control over his own destiny. It also gives him a collateral responsibility for the destiny of his fellows.

People of all ages are enjoying the new powers of modern society, but they are rarely fully aware of the responsibilities that these entail. When they feel unable to cope with increasing responsibility, they are thrown into confusion, a confusion that leads to emotional insecurity, conflict, and even to insanity.

As thoughtful people, standing in a strategic position, we might well recall the warning, "Whom the gods would destroy, they first make mad." And the first line of defense against this form of madness is the strengthening of our educational purposes and forces.

BOOK REVIEWS

Adventure in Mental Health: Psychiatric Social Work With the Armed Forces in World War II. Edited by Henry S. Maas. New York: Columbia University Press, 1951. 334 p.

Here is a long awaited book! One that tells something of the story of the contribution of psychiatric social work to the efforts of psychiatry within the armed forces during World War II. However, lest it be thought of as a static history of an important adaptation of civilian skills to military purposes, it offers much that is not only current, but forward-looking for clinical services and community programs.

Presented as a symposium by sixteen psychiatric social workers, the volume is exceedingly well organized. It follows a logical sequence and the cohesiveness of the content is a tribute to the editorship of Dr. Maas. Rarely have the efforts of so many authors been blended so admirably to a single purpose. The book is organized in three parts: Part I, *Psychiatric Social Work in the Field,* has eight chapters. Beginning with the background that psychiatric social workers brought to their military experience, it moves into their more specific operations in a mental-hygiene unit in the army air force, a combat division, a neuropsychiatric hospital, a convalescent hospital, a disciplinary barracks, the coast guard, and the navy.

Part II is entitled, *The Upper Echelon Story.* The first two chapters of this part are devoted to the efforts of the American Association of Psychiatric Social Workers to gear itself to the national emergency and, with the collaboration of The National Committee for Mental Hygiene, to establish the War Service Office. The fruits of these early efforts are seen in the two following chapters which cover the development of the army's psychiatric social-work branch in the consultants division of the Surgeon General's Office and the growth of the program to-day. The remaining three chapters in Part II deal with the navy story, American Red Cross psychiatric social work, and the selective-service medical-survey program.

Part III, *Implications for Current Civilian Practice,* concludes the volume on a high note. In two forceful and creative chapters many provocative ideas are advanced for practice to-day and work to be done in mental-health education and research. The appendixes offer some nostalgic moments for those closely identified with the origin of military psychiatric social work, and some original formulations which may be taken as models of policies, practices, and procedures

for those to whom these documents are new. An addendum, *About the Authors,* indicates that these authorities were strategically placed to gather the content about which they write and had the professional background to be able to see it in perspective. The index is well done and rounds out the book.

Since it is unlikely that a detailed history could be compiled or would have sufficient interest for widespread distribution, the manner of presentation is doubly fortunate and should insure the wide audience the book deserves. While it is true that the authors gained more than they have been able to project, one senses their wish to share their unique experience, which they know has implications for psychiatrists and social workers in whatever settings they may practice.

It is regrettable that a history of military psychiatric social work is not publicly available, since it would be a human document reflecting a prodigious effort which successfully established a profession within the army that was officially unrecognized throughout the major part of World War II. In such an account the individual efforts of a few psychiatrists and laymen (military and civilian) along with the men who did the job, would truly be in evidence. It is unfortunate too, that it was not possible to include a chapter on the mental-hygiene unit in the training center. It was in these installations that the military psychiatric social workers were first utilized and identified by their own professional title. It was also in these installations that psychiatric social workers first demonstrated to the military that they had a valuable technical service to offer. These comments would not occur to any one not intimately connected with the development of the subject and in no way detract from the essential value of the work.

The book is timely. Present-day problems of simultaneously maintaining a peace-time-war-time economy, with attendant problems of man power, selective service, and priorities, pose serious difficulties for the agencies set up to help individuals in times of stress and crisis. The clinical team of psychiatrist, psychiatric social worker, and clinical psychologist has proven itself an invaluable asset in community resources. The psychiatric social worker, long since identified as the backbone of the team, is here shown to proper advantage.

It is fitting that the book has been dedicated to Dr. Marion E. Kenworthy, "who has through the years worked so effectively and tirelessly for Mental Health Teamwork, an integration of Medical, Psychological, and Social Services."

HARRY L. FREEDMAN

Classification Clinic,
Clinton Prison,
Dannemora, New York

THE HEALTH OF THE MIND. By J. R. Rees, M.D. New York: W. W. Norton and Company, 1951. 207 p.

A book or article by Dr. Rees, Director of the World Federation for Mental Health, is always good news. What he writes is always clear and always sound. This little book is designed as an elementary presentation, for the intelligent layman, of mental health, its acquisition and maintenance.

After a preliminary chapter on mental health in general, Dr. Rees discusses "The Physical Machine," "Instincts and the Personality," "Mind and Body," and "Psychological Mechanisms." He then turns to "Mental Breakdown: Its Cause and Its Cure," "The Problems of Early Life," "The Problems of Childhood and Adolescence," "Adult Problems," then "Sex Education," and finally "The Art of Adjustment."

Dr. Rees's approach is in line with modern concepts, but not blindly partisan. His attitude is optimistic, humane, and "common sense."

His philosophy is summed up well in the following passage (page 199):

> "There are three main lines along which adjustment is needed, toward ourselves, toward society, and toward the Infinite. Adjustment to one's self will always be difficult if we have been given the impression that we are unduly valuable or precious. We are reluctant to give up our belief in our own importance, even if we recognize intellectually that it is irrational or untrue. Very many of the fundamental difficulties of life result from our failures to reconstruct our feelings on this point. The social adjustment, which includes our relationship to all our friends, to marriage, and to the larger society outside, is dependent to some extent on the attitude which we have toward ourselves, but also is hampered by our wrong thinking about the herd and by the faulty judgments of others which have taken place in earlier stages of our life. Adjustment to the Infinite is a matter which every one will have to express for him or herself in their own way. There is something in every one which demands an explanation or philosophy of life which goes deeper and further than anything we have yet said in this book. Science can only go a certain way; there is always something that lies beyond what we know as fact. It is evident to the medical psychologist that a self-centered person whose interest is turned pathologically upon himself can only get well and has only got the inducement to do so if there is something in life that is more worth loving than himself. That is to say, we must have ideals, and these ideals must be the highest that we can find. It may be true that, in our attempts to get nearer to perfection, through understanding more of our minds, and through better touch with what we have called the unconscious, we are in fact getting into closer touch with spiritual factors."

The book can be highly recommended to any one who wishes to gain a practical glimpse into what psychiatry is about.

Saint Elizabeth Hospital,
Washington, D. C.
WINFRED OVERHOLSER

THE PSYCHOLOGY OF MENTAL HEALTH. By Louis P. Thorpe. New York: The Ronald Press, 1950. 747 p.

To the average college student interested in psychology, a course in abnormal psychology is regarded as a "must." Not only does the student feel that some knowledge of the abnormal is requisite to an understanding of the normal individual, but the study of mental cases has much the same lure for him as ghost stories did when he was a child.

No college professor would deny that a real understanding of the normal individual is incomplete without some understanding of why and how certain individuals deviate from the normal. Too much emphasis on the abnormal, however, without an adequate background of information about the normal, may result in a distorted point of view about the normal.

In Thorpe's most recent book, *The Psychology of Mental Health*, the gap between the normal and the abnormal has been bridged in such a way as to enable the undergraduate college student to get a clear perspective on the whole subject. Enough space is devoted to the different psychoneuroses and functional psychoses to give him as much information about these disorders as is necessary to satisfy his curiosity about them and at the same time to understand the normal. When presented with facts relating to minor disorders, he is led to regard these deviations as differences of degree, not of kind.

The book is designed primarily to teach the fundamental principles of mental health and to enable the student to see what is essential to the "fullest possible development of personality, as well as harmonious interpersonal relationships," which, Thorpe maintains, are the objectives of mental hygiene. Because mental disorders are on the increase to-day, presenting a problem that is becoming more and more serious with each passing year, schools and colleges are faced with the task of preventing these disorders from reaching the point where institutional care will be needed. Any student whose life work is to be that of a parent or a teacher should become thoroughly familiar with the fundamental facts about mental health and should know how to apply these facts in guiding the personality development of those who come under his supervision.

The book is divided into five sections, each dealing with important areas of behavior. Part I, the shortest of the five, gives information about the mental-hygiene movement and the rôle it plays in modern society. Part II, *The Psychodynamics of Mental Health*, contains a detailed analysis of psychoanalysis and its relation to mental health, a survey of different adjustment mechanisms, and an evaluation of mental health. Part III, *Personality and Mental Health*, includes

an excellent and very comprehensive survey of facts about personality, its development, and the factors in the life of the individual that determine what form personality will take. Major emphasis is placed on the relationship of personality to mental health.

Part IV, *Conditions Marked by Inadequate Mental Health*, is a follow-up of Part III, with stress on minor personality maladjustments, psychosomatic disorders, hostile behavior, deviate sexual behavior, the psychoneuroses, and the functional psychoses. The final section, Part V, is devoted to the problem of improving mental health, with detailed discussion of what contributions can be made by the home, the school, and the community. The closing chapters of this section are given over to the question of how to diagnose mental health and personality, and to a discussion of the therapeutic methods that might be used.

In the section of the book in which minor personality maladjustments are discussed (Chapter 7), too little emphasis, it seems to this reviewer, is placed on childhood experiences. The chapter on psychosomatic disorders (Chapter 10) should prove to be especially interesting to the reader because so few of the textbooks meant for undergraduate students include this material.

Whenever maladjustments are discussed, whether they fall into the category of major or minor, there follows a section on how these disorders may be treated and prevented. The reader who is planning or hoping to make practical use of the material acquired through his study of the book is not left up in the air, as is so often the case, regarding the question as to what practical steps may be taken should he come face to face with one of these problems. These sections, it seems, are especially valuable and are one of the outstanding features of the book.

Interesting pen-and-ink sketches are scattered sparsely throughout the book. Because the subject matter itself is heavy, it is regrettable that more illustrations of this sort have not been used. In spite of the fact that the book is very long even for a college textbook (747 pages), a slightly longer book would not have been overwhelming had it been devoted to more case histories, which would have lightened the quality of the material even if it had added to the physical weight of the book.

Throughout each chapter, there are copious references to experimental studies, used to illustrate and to substantiate the subject matter. Many of these date back to the '30's or even the '20's. For a book that is to be used during the second half of the century, it would have been wise to reduce these older references to a minimum and to put more emphasis on later references. Only when no recent

work has appeared does there seem to be any real justification for quoting in detail a study that is twenty or twenty-five years old.

Because many of the technical terms used throughout the book will be new to the reader, Thorpe very wisely gives an excellent glossary of such terms at the end of the book. An added feature of interest and importance is the pronunciation key, which shows students how to pronounce these new terms.

By the time the student has read this book from cover to cover, he will not only have a very complete picture of the entire field of mental hygiene, but—of even greater importance—he will finish his course of study with an appreciation of how serious a problem mental ill health is. It is to be hoped that he will carry away with him the desire to see to it that he, as well as all with whom he lives and works, develop good mental health.

ELIZABETH B. HURLOCK.

University of Pennsylvania,
Philadelphia.

CURRENT TRENDS IN THE RELATION OF PSYCHOLOGY TO MEDICINE. Edited by Wayne Dennis. Pittsburgh: University of Pittsburgh Press, 1950. 189 p.

The aim of the lecture series presented in this book was to bring together several men—some of them physicians, some psychologists—who represent the forefront of thinking and research in a number of areas in which psychology and medicine overlap, in an attempt to answer the following questions: (1) What has psychology, as a separate scientific field, offered in the past? (2) What does it have to offer now? and (3) What does it propose to offer to medicine in the future?

The eight lectures that make up the series are: (1) *Interrelations of Psychology and Medicine,* by Wayne Dennis; (2) *Psychology and Public Health,* by Robert H. Felix; (3) *Psychology in Medical Education,* by Carlyle Jacobsen; (4) *Experimental Psychopathology,* by Robert A. Patton; (5) *Psychology in Neurological Research,* by Yale D. Koskoff; (6) *Psychology in Relation to Psychiatry,* by Paul E. Huston; (7) *Psychology and Gerontology,* by Nathan W. Shock; and (8) *Relation Between Medicine and Psychology In England,* by Hans J. Eysenck.

The reader will learn that current attempts at fostering close interdisciplinary training are not as new as one may have been led to suppose. Men with medical training have contributed much to psychology —Locke and Hartley were both physicians. In a later era, the men who were most instrumental in initiating modern experimental psychology were Fechner, Helmholtz, and Wundt. Each of them held an M.D.

degree. Among current psychologists whose education has included the M.D. degree are Norman Cameron, Henry A. Murray, and James G. Miller.

The contributions of medical men that have greatly influenced psychology have had to do not only with the nervous system and the senses; they have involved areas that may be thought of as most truly psychological—*e.g.*, hypnosis (Mesmer), psychodynamics (Freud), projective techniques (Rorschach), and learning (Pavlov).

Eysenck's discussion of the proper functions of the clinical psychologist will probably evoke much critical comment from clinicians who are prone to regard psychotherapy as within their legitimate field of endeavor. Eysenck, on the contrary, feels that it should be exclusively in the hands of the psychiatrist, lest the psychologist become an unnecessary substitute for the psychiatrist, when he should be fulfilling the traditional complementary rôle of diagnostic testing and research.

The book should clarify the relationship of psychology to medicine in its many areas for both professional and lay readers, and should be of particular value to graduate students in clinical psychology.

SIDNEY YUDIN.

Neuropsychiatric Institute, Ann Arbor, Michigan.

FEELINGS AND EMOTIONS. Edited by Martin Reymert. (The Mooseheart Symposium.) New York: McGraw-Hill Book Company, 1950. 595 p.

This is a carefully prepared, scientifically arranged volume, valuable for reference and resource purposes. The book marks another milestone in the reporting of developments in the field of feeling and emotion, bringing the interested reader up to date. Forty-seven scientists have contributed short reviews of their thinking or descriptions of their experiments. If the book suffers from omissions, it is because the amount of work done in this field has reached such proportions that no one could hope to include the efforts of all workers in one symposium. As it is, the volume contains 595 pages, and reading it from end to end is quite a task. The editor, however, has divided the material into ten sections, which makes it easier for the discriminating reader to select topics of particular interest to him.

A review of the content of the material presented in the book with a bias for those interested in mental hygiene is very difficult because of the great diversity of topics. That there is virtue in this wide array of material is demonstrated by the fact that one can sit down after reading the book and rebuild one's own frame of reference in relation to the problems of mental health, and that this frame of reference can

be based upon a much sounder foundation than was possible when the earlier Wittenberg symposium appeared over twenty years ago.

It will undoubtedly be a disappointment to psychologists, clinicians, and social scientists to discover that their colleagues can produce so little in the way of research findings and that most of the research is contributed by the experimentalists and physiologists. This is undoubtedly the way it should be, but it means that sound mental-hygiene practices must still await the tedious, methodical work to be done in the laboratory. In spite of the topical arrangement of the book, the basic research must be teased out from a great volume of words. When finally unearthed, some of it is found to be only suggestive, while some does give real clues to better management of mental-hygiene problems.

Much of this volume, as was the case with its predecessor, is given over to the presentation of ideas about what emotions are. These ideas are interesting and provide food for thought, but unfortunately they show us how much of our knowledge is still in the philosophical stage, a fact that those of us who are scientifically oriented hate to admit. The implications for mental hygiene are that much of our practice must still derive from premises growing out of what we think is right rather than from scientifically established fact.

In spite of its weaknesses from the standpoint of content, the book warrants a careful scrutiny by every serious clinician, and will be read with interest by the experimentalist and the social scientist.

Roy F. Street.

Grand Rapids, Michigan.

THE HANDICAPPED CHILD: A GUIDE FOR PARENTS. By Edith M. Stern with Elsa Castendyck. New York: A. A. Wyn, 1950. 179 p.

Parents of handicapped children will welcome this book, which presents an excellent account of mental-hygiene procedures. The child's basic needs for love, security, and a sense of achievement are discussed in a practical manner.

There is a very helpful attitude throughout the book which tends to reduce parental guilt and anxiety. The authors' advice to "find a major ally in God" is old-fashioned, but refreshing, when most modern texts have substituted fact for faith.

There are chapters dealing with the crippled, the cerebral palsied, the epileptic, the blind or partially sighted, the deaf or hard of hearing, the retarded, the speech handicapped, and the child suffering from rheumatic fever or chronically invalided.

The text is clearly written and the explanations of medical conditions are correctly and simply formulated. The suggestions are help-

ful and can be used by physicians and nurses when they are asked to advise parents. Thus the authors state that there is no use in advising the parent of an epileptic child not to worry, because he is "bound to worry," and they suggest that the child's handicap be called by its right name, so that a realistic attitude may be maintained both by child and by parent.

It occurred to the reviewer that the authors might consider printing each chapter separately and offer these excellent discussions to organizations and to the parents of children with various types of handicap.

The book is an excellent piece of work. It is not only a helpful guide for parents, but a practical handbook for the psychiatrist, the social worker, and the clinical psychologist.

J. H. Conn.

Johns Hopkins University School of Medicine,
Baltimore, Maryland.

Child Psychiatry in the Community—A Primer for Teachers, Nurses, and Others Who Care for Children. By Harold A. Greenberg, M.D., in collaboration with Julian H. Pathman, Helen A. Sutton, and Marjorie M. Browne. New York: G. P. Putnam's Sons, 1950. 296 p.

Here is an excellent introduction to the work of the child-guidance clinic. It is written clearly and unpretentiously; it avoids the pitfalls of oversimplification and condescension, and presents basic facts carefully and thoroughly and with close attention to clinical realities.

The book is divided into three sections—the first on the child, the second on the clinic team, and the third on the clinic and the community. In the first section, there are chapters on personality development, psychogenesis, clinical syndromes, prognosis, and treatment. The second section discusses the functions of psychiatrist, psychologist, and social worker. The final section includes chapters on the psychiatrist's rôle as consultant in a children's institution, and in a hospital-school for crippled children. It discusses the assistance that child guidance may offer to the nurse and to the teacher. There is also a short discussion of juvenile delinquency. The appendix contains samples of statistical reports, and of clinic forms used at the Institute for Juvenile Research. A glossary of terms and a list of selected readings are useful additions to the book.

The first two sections of the book are written with a great deal more authority than is the third. It is interesting that there is actually no general consideration of the rôle of the clinic in the community, its place as a social and health agency, and its responsibilities in the pattern of community-service programs. There is no discussion

of the clinic board as representative of the citizenry of the community, with all the problems attendant thereto. This is the most serious lack in an otherwise informative and thoughtful book.

One might also have wished for somewhat greater emphasis on the problems of parents, particularly the mother, in the relationship to the child and in treatment. There is perhaps not enough recognition of the high level of sophistication and competence that many clinics have achieved in the collaborative practice of case-work with the mother. However, this is a matter of emphasis, and certainly not one of neglect.

The book may be highly recommended to many groups: workers in social and health agencies in the community; students in social work, psychology, and psychiatry; board members; beginning workers in clinics; teachers and ministers, and other persons who may refer problems to a clinic. It should be of interest to all workers in the field of child guidance.

New Haven, Connecticut. JULES V. COLEMAN.

WORKING WITH TEEN-AGE GANGS. By Paul L. Crawford, Daniel I. Malamud, and James R. Dumpson. New York: Welfare Council of New York City, 1950. 162 p.

Warfare between street gangs was a daily occurrence in most of the boroughs of the city when, in October, 1945, the Welfare Council of New York City, acting largely on impetus imparted by the Prison Association, organized the Committee on Street Clubs. Primitive weapons had been discarded and the boy gangs "rumbled" with guns and knives. The infantry soldier was supplemented by the mobile corps, who moved about in taxis and splattered the enemy and often the innocent with lethal lead. Casualties were high and fatalities not uncommon. This book describes the committee's efforts to bring peace to the streets of the city.

The committee believed that the street club could be directed into constructive activities. They studied the gangs and stated their opinion that "if properly guided, the street club could give the adolescent increased emotional security, develop his loyalties along positive lines, and help to stimulate a sense of community responsibility." The committee recommended area projects to encourage neighborhoods to develop resources for meeting the needs of the youths and to provide trained workers to seek out the gangs and gain the confidence and acceptance of their members.

Costs were so great that the study was finally limited to the Central Harlem area. Four of the five area workers were Negroes; one was a

woman. All were acquainted with the area. They operated from a loft building in the area. They worked with four gangs, ranging in size from thirty-five to one hundred members, and in age from nine to twenty years. The gang structure, activities, and interrelationships are described in the book under review, but the bulk of it is concerned with what the workers learned in the course of their work.

The workers are not credited with authorship, yet it is they who write this book. Long and detailed excerpts from their records are quoted to show how they developed relationships with the gang members by "hanging around" or by "looking for apartments." With appropriate timing, they revealed themselves and their purpose to the boys. Theirs was no complicated approach to relationship, but a simple one. A worker writes, "The very fact that you stand there and talk to a boy for fifteen . . . minutes indicates that you are interested in him."

The quotations are interspersed with summaries and descriptions that give the book a scenario-like quality and high readability.

The workers organized athletics, dances, parties, movies, hikes, camping, and fishing. One chapter tells of the workers' struggle with the boys (and with themselves) to get them to take over self-direction in these activities. Their difficulties in this effort recall the reviewer's observation that delinquent boys tend to respect and lean on the teacher who is something of the martinet.

Most interesting is the description of the workers' approaches to antisocial behavior. Most often they were neutral. When they felt that they had a sufficiently strong relationship, they attempted to influence the boys away from destructive and illegal activities. Some nice words are written about helping the boys individually to insight into their activities, but this does not seem to have been a crucial factor in the movement to acceptable behavior. They succeeded because they liked the boys, and the boys liked and identified with them and wanted to please them. The vow of one boy to become a "respectable hoodlum" points up both the inroads made into his self-concept and the retention of old identifications. The boys seemed to borrow some superego from the workers.

The workers were concerned primarily with the dynamics of the group, but much time and effort were given to individual boys. The workers attempted to bolster the faltering self-esteem of the boys and to encourage ambition and positive self-feelings. They gave educational and vocational advice, taught skills in group participation, and referred cases for psychiatric help. Though relationships with individual boys were not so labeled, they were essentially psychotherapeutic. What else is an effort that fosters the development of

self-direction, self-confidence, and responsibility? Yet these efforts were not recognized as such; in the reporting there is a surreptitious quality to them.

It may reasonably be argued that a group project with limited personnel should not focus on individual therapy. However, the account shows that in this project transferences were created, but not adequately followed through. Much too much work with delinquents is guilty of the "dangling transference." Classically, the therapy of delinquents has two distinct stages: first, the development of transference, which is climaxed by the borrowing of superego and the abandonment of delinquent behavior; second, insight therapy. Without planning by the worker, the shift from the first to the second stage seldom occurs. Perhaps future street-gang projects will recognize the need for both stages in their design, and provide for group or individual therapy that carries through to that essential second phase.

What is striking throughout the book is the willingness of the workers to depart from traditional and structured practices to meet difficult situations. Since the situations they worked with were unorthodox to begin with, and changed rapidly and in most unpredictable ways as the project progressed, this flexibility was clearly necessary—lesson number one of the report.

The workers believed that the street gangs were primarily a community problem and attempted to organize interested adults into a neighborhood council to help. Participation was limited to a few members and their efforts often met with failure. At the bitter end, four adults constituted the council, but the workers questioned how long even these four, in the face of obstacles and discouragement, would continue their efforts—lesson number two.

People everywhere who are involved in this problem will be interested in the concise treatment of techniques and guides for working with these groups. Here are both the distillations of experience for workers and the basis for improved area projects for planners of the future.

LEONARD SMALL.

Vocational Advisory Service,
New York City.

UNDERSTANDING GROUP BEHAVIOR OF BOYS AND GIRLS. By Ruth Cunningham and Associates. New York: Bureau of Publications, Teachers College, Columbia University, 1951. 446 p.

Precisely what complex of forces is making interest in group life in the classroom so central in current educational thinking, it is difficult

to say. The renascence of the ideals of grass-roots participation, the advent of sociometrics, the experiments of Kurt Lewin and Ronald Lippitt on autocratic and democratic groups, the clinical and research work of Fritz Redl, the real pressures on teachers who have to handle swelling classes—all probably have a bearing on our school personnel's eagerness to learn more about group processes.

For such people in the field of education, Ruth Cunningham and her associates have written a book rich in ideas, fruitful questions, and tentative answers based on their "action research" primarily with a first-grade, a fourth- and a fifth-grade, and an eighth-grade class. This informally written and easy-to-read report presents a plethora of tables and charts, but always with some such comment as the following: "The figures we present tell something about the groups with which we are working, but do not necessarily tell anything about *your* group. As we have said before, we feel that *each* group must be studied in its particular setting, and that this study is the job of every teacher" (p. 97).

This repeated invitation to teachers to join with others in the study of group interactions, group culture, group goals, and group structure in their classrooms is a refreshing change from the idea that "research" is something reserved for the "experts." It might also, however, be a frustrating appeal if the authors did not first present in detail the kinds of study technique they used and then explain how investigations can themselves develop as group adventures, involving teachers, parents, pupils, and administrators, as well as consultants from a university faculty.

To give possible readers of this book a good idea of its contents—to help them decide whether it is worth purchasing or borrowing from the library—this reviewer finds an exceedingly difficult task. The fragments one is tempted to quote from the book are chiefly the questions it raises, and, taken out of context, these may seem unrewarding. One resorts, therefore, to such direct counsel as the following: By all means, if you are working with children in school, if you are at all interested in children's social behavior, their peer groups, and the relationship of such factors to curriculum, by hook or by crook get a copy of this book and read it. It is alive; it is definitely not another ivory-tower book of formulæ for solving all one's classroom problems; and it is a first-rate substitute for some of the standard texts in educational psychology whose laboratory experimental bases make them of little value to the teacher who has to deal with live boys and girls in groups—precisely what this book deals with.

From a research point of view, one may question some of the fragmentary, abortive, and unintegrated sallies into investigations of such questions as the relationship of I.Q. and socio-economic status to

"social distance." In the course of this "action research," one regrets somewhat that existing literature on small groups receives scant attention or credit. A firmer theoretical basis for this report might then have preceded the study or developed out of it, and perhaps then, too, the whole presentation might have seemed somewhat better knit. But taken for what it is—an enthusiastic and thoughtful report on group life at school—this book should be read and discussed widely by teachers and school administrators.

HENRY S. MAAS

University of Chicago.

HOW IT FEELS TO BE A TEACHER. By Mary V. Holman. New York: Teachers College, Columbia University, 1950. 208 p.

More than one teacher these days comes to the end of a series of discussions or courses on the work of the teacher with a feeling that the demands being made upon her are so extensive and so complex as to be almost overwhelming. This is particularly felt in relation to the field of human relationships, which, it is emphasized, is a major area of the teacher's work. Here the teacher is asked to have a very positive, very ideal attitude toward each and every child, bright or dull, poor or rich, submissive or aggressive; toward each and every parent, be he interested in his child's education or not; toward school supervisors and administrators, whether they are helpful or merely critical; and toward the local community, whether or not the individuals therein follow behavior patterns in line with the particular teacher's own upbringing and present ways. The professional necessity of engaging in these relationships may well bring forth different feelings from those that would be aroused if the teachers sought these relationships by choice.

It is now fashionable for books in educational psychology and sociology to stress the difficult adjustment that a "lower-class" pupil must make to a "middle-class" teacher, but rarely is much discussion given to the feelings of a teacher who must deal with the pupils of a community whose values are unlike hers and negate hers. The voluntary, idealistic "missionary" is emotionally set to adjust to the human relationships peculiar to the locale in which he chooses to do his work and this "set" eases the many adjustments he must make. One of the purposes of Mary V. Holman, in her book, *How it Feels to be a Teacher,* seems to be to try to give teachers a similar emotional set by laying before them the network of human contacts in which they have to operate and asking them themselves, through "constructive introspection," to examine the feelings likely to be aroused in them in these usually tension-producing situations.

While the title of the book might suggest that the anecdotal records which the author gathered directly from teachers with whom she has worked as a colleague, as a college instructor, and as a guidance counselor, would be outpourings of feelings that teachers are expected publicly to restrain, this is not at all so. The author seems rather to have selected incidents that were obviously feeling-producing to the teachers who recalled them and that one might expect to be feeling-producing to most teachers who encounter similar situations, but in which the recorders referred to their own emotions only in an oblique and indirect manner. Whether the author purposely chose to use only such anecdotes, or whether her manner of gathering them brought her sketches mostly of this kind, or whether experienced teachers engaged in serious graduate work (the group from whom the bulk of the material was obtained) no longer write with an outpouring of feeling, one cannot tell. It may be that the book is the stronger for not living up to its title.

With the first several chapters devoted to the biography of "Doris Jensen" (now a teacher fifty-seven years of age) from her earliest school days to the beginning of her professional career, the author suggests that the teacher's experiences up to the time when she becomes a teacher will greatly affect her feelings in the various situations she meets when she is practicing her profession. Though how Doris' upbringing did affect her teaching adjustments is not gone into, the teacher-reader is urged to go back over her own life, so that she may come to recognize why some of her feelings are what they are. She is not told that if she has been brought up in circumstances stereotyped under description *A* she will, therefore, have feelings stereotyped under description *Y*. This technique of setting the problem areas before the teacher, but leaving her to figure out her own feelings therein, may reduce the stereotyping of themselves that, unfortunately, many teachers engage in while deploring this stereotyping on the part of others.

Certain it is that part of the teacher's difficulties arise out of the narrow stereotype which many communities insist that the teacher become. Other difficulties arise because the teacher is not emotionally mature enough to make successfully the life adjustments she is called upon to make and which generally demand a very high degree of emotional maturity.

All in all, the greatest contribution of Dr. Holman's book would seem to lie in its adding to the awareness, both of the profession and of the lay public, that the teacher's job, usually thought of as an intellectual one, is equally a task in human relationships.

Queens College, BERTHA B. FRIEDMAN.
Flushing, New York.

HOMES MAKE PERSONS. By Garry Cleveland Myers, Ph.D. and Caroline Clark Myers. Philadelphia: Dorrance and Company, 1950. 329 p.

This book is a happy combination of broad, general principles as they should function in the home and of specific, often minute, step-by-step illustrations of just how these principles can be applied to bring about the wholesome character growth that will result in full maturity and a dynamic and responsible adulthood. In the preface, the authors state frankly that they are in revolt against the prevailing philosophy and practice of excessive self-expression, but that they do favor self-expression in the growing child so long as his own self-expression does not interfere with that of those about him. They show how the home, through its parent-child relationships, can build up during his early years the child's own self-control and respect for the rights of others. They believe that, given a happy family atmosphere, children can be led to choose for themselves desirable ways of behavior.

There are separate chapters given to full discussions of home atmosphere; husband-wife relationships; affection; self-reliance; positive factors in guidance; education in responsibility; the child and his money; socializing the child; means of control; property attitudes and habits; mental health, character, citizenship; and spiritual aspects of moral growth.

Dr. and Mrs. Myers need no introduction. Both are well known in psychological and educational fields. They have three children and eleven grandchildren of their own. Witness the happy group in the frontispiece. They have a right to speak with authority. Both are endowed with keen insight into children's minds and feelings. They have rare ability to present techniques so clearly and at the same time so forcibly that the reader cannot fail to grasp the underlying "why" for every "how." A complete index makes the material readily available for quick reference in time of need. The book is a generous sharing of wisdom gained through years of study and of happy practical living. We cannot recommend it too highly to parents and to any one responsible for children.

JULIA MATHEWS.

Hermosa Beach, California.

SCHIZOPHRENIC ART: ITS MEANING IN PSYCHOTHERAPY. By Margaret Naumberg. New York: Grune and Stratton, 1950. 247 p.

More than ten years ago, Margaret Naumberg began to write about her use of free art expression for diagnosis and therapy with neurotic

and behavior-problem children and adolescents. In 1947, six of her previously published case studies were collected in a 225-page monograph. Five of those case reports were of boys from five to ten years of age; a fifteen-year-old girl was the only adolescent, as well as the only girl, included.

The book under review presents Miss Naumberg's far more detailed case studies of two older girls, aged, respectively, eighteen and twenty-five years. Both girls had been diagnosed as schizophrenic, although Harriet, the eighteen-year-old, apparently was much less withdrawn and unrelated than twenty-five-year-old Elaine. Sodium-amytal interviews and insulin therapy had been tried both with Harriet and with Elaine prior to starting the art sessions. Both girls had written poetry, and many of their poems are quoted. While intelligence tests gave Harriet an I.Q. of 97 and Elaine an I.Q. of 137, Harriet's poetry and her verbalizations generally suggest that she probably was more intelligent than the results of her intelligence test would indicate.

Harriet's mental illness had been developing for about three years before she started art sessions with Miss Naumberg, although she had been hospitalized only a month before these sessions were begun. Her symptoms consisted of psychosomatic complaints, the telling of fantastic stories, and depressed moods in which she often wandered away from home, with little memory afterward of where she had been or what had happened during such runaway episodes.

Elaine had been mentally ill for some six years before Miss Naumberg began to work with her and had shown signs of emotional conflicts from the time when she reached puberty at thirteen. Between the ages of nineteen and twenty, she had been hospitalized twice; for five years afterward, she had been seen for psychiatric interviews whenever she was in the city. After her hospitalization, Elaine was able to maintain superficial contacts, to travel about the city alone, and to attend classes in painting, but when she resumed university-extension courses, in which she had done satisfactory work between the ages of seventeen and nineteen, she was requested to drop them because she disturbed other students by her frequent inappropriate laughter. Prior to her hospitalization, Elaine had voiced fears of lesbianism. By the time she was seen by Miss Naumberg, she had adopted a distinctly masculine type of costume, of military style.

Harriet came to art sessions with Miss Naumberg twice a week for six and a half months, during which time she remained in the hospital. In discussing her artistic production, Harriet was able to express her conflicts about her relation to her foster mother, with whom she had lived from the age of three. She recovered many childhood and adolescent memories, and worked through some of her conflicts about sex, her experiences with men, and so on. Besides drawings and

paintings that symbolized her emotional conflicts, memories, and experiences, Harriet produced pictures expressive of her transference to Miss Naumberg and others that represented her increasing insight and improvement.

It was considered unfortunate that she was permitted to terminate her stay in the hospital before the series of drawings and paintings concerning her relations with men was completed. Before leaving the hospital, Harriet had wished to continue her art sessions after going home; her foster parents objected and she did not continue. However, the case was carried for six months in the outpatient department, but contacts were infrequent because of resistance on the part of Harriet and her foster parents. After the girl returned to the foster home, there was a period during which she would stay out late at night with friends she had made at an art school she was attending, and on one occasion she stayed out all night with a man. These behavior problems were said to have subsided before the outpatient contacts were discontinued at the foster mother's insistence.

That Miss Naumberg was able to accomplish a great deal with Harriet in six and a half months will not be surprising to any one familiar with her therapeutic skill from reading her previous publications. Moreover, although diagnosed as schizophrenic, the description of Harriet's symptoms, conflicts, and experiences is not extremely different from descriptions that might be given of some of the adolescents treated in child-guidance clinics. That anything at all could be accomplished with Elaine, whose illness seemed so much more severe and had persisted over so long a period of time, is indeed amazing. Actually, Miss Naumberg had little opportunity to discover how much could be achieved, for she had only twenty-nine continuous art sessions with Elaine, followed by irregular and brief periods when further sessions were possible during the next two years. Yet there were apparently reliable statements that Elaine's contacts with family and friends improved, that her personality seemed better integrated, and that she became more independent and self-reliant.

This book is not just a report of two case studies. It is chiefly important because it is a remarkably clear exposition of the therapeutic techniques employed by Miss Naumberg. Since it contains many reproductions of the art work of the two patients, it is possible for the reader to gain a good understanding of these techniques. While reading, one can turn from the text to the illustrations; can learn how each part of a drawing, painting, or sculpture has a meaning, and how associations to the different forms and colors in a work of art may be as revealing as associations to dreams.

To utilize Miss Naumberg's methods with the same degree of skill

that she does would, of course, be impossible for the therapist who does not have the same experience and knowledge of art, in addition to training and experience in psychotherapy. Yet even a less skillful utilization of art sessions may enable one to work therapeutically with a child who does not willingly verbalize or dramatize in play, but who is willing to draw and to talk about the details of the drawings. Personal experience leads to this last statement, for the reviewer recently completed therapy with a six-year-old girl who would play very rarely and would talk very little except about the drawings that she made during her interviews. Thanks to what had been learned from Miss Naumberg's writings, therapy with this child was as successful as with a child who could verbalize more easily. Even the transference relationship and the feelings about ending the therapy were discussed in connection with the child's drawings.

As a background for the two case studies and the description of her therapeutic methods, Miss Naumberg has an introduction in which she reviews the literature on the art productions of psychotic and neurotic patients from 1876 to 1950. Thus we finish reading her book with the conviction that she is a scholar, as well as an artist and a therapist.

PHYLLIS BLANCHARD

Philadelphia Child Guidance Clinic

COUNSELING IN RESIDENCE HALLS. By Rhoda Orme. New York: Bureau of Publications, Teachers College, Columbia University, 1950. 143 p.

Time was, and not so long ago, when institutions of higher learning considered themselves responsible only for the intellectual development of their students. In those days, dormitories were thought of as unavoidable nuisances, "merely providing safe and healthful living," a protected environment for the young from the vicissitudes of life on the outside.

With our newer understanding of the human being and the realization that the whole student is admitted to college, institutions have come to acknowledge that education involves not only the student's intellectual training, but also "his emotional make-up, his physical condition, his social relationships, vocational skills and aptitudes, his moral and religious values and his æsthetic appreciation." In the setting of this new understanding, according to Rhoda Orme, author of *Counseling in Residence Halls*, dormitories assume a vital rôle in "contributing to the students' all-around development, in helping them to become socially competent, intelligent, well-balanced persons, having concern for the welfare of others."

Miss Orme's book, one of the few on the subject, is very readable and practical, and is organized so that it can easily be used for reference. Statements and premises are clarified by excellent examples, and case citations are well chosen from the standpoint of being typical, to the point, and interesting.

The position is well taken and proven that "dormitories are centers of counseling," a "real challenge of helping students find themselves, establish values, and achieve an orientation toward the world." And Miss Orme has approached this position from many angles with considerable thoroughness. Perhaps she has attempted too much, too briefly, since the book is addressed to "inexperienced counselors" as a non-technical guide.

Yet in view of the lack of printed information on the counseling aspects of the residence-hall program, this small volume is an especially valuable addition to any guidance library. It holds many practical suggestions and stimulates further exploration of necessary knowledge, skills, and techniques and the development of improved procedures in setting up dormitories as natural counseling centers, creating a "mental climate which facilitates growth."

The bibliography is well selected and should be of much value to the inexperienced counselor.

ESTHER M. DIMCHEVSKY

University of Denver

DIAGNOSIS AND PROCESS IN FAMILY COUNSELING. Edited by M. Robert Gomberg and Frances T. Levinson. New York: Family Service Association of America, 1951. 243 p.

Counseling is a process that has been used by many disciplines in response to an evergrowing need of people for help in their personal lives and in their interpersonal relations. With the advent of Freud and the others who have contributed to our knowledge of emotional development and motivated behavior, it has become evident that no one can aid another person without such knowledge.

Integrating such concepts and methods with their own has made many counselors aware of such problems as: Are they overreaching into analytic therapy? Are they doing as well as other psychotherapists? Are they, perhaps, doing better? What are their limitations? Are they qualified? Should they have safeguards? Should they have consultants? Can they practice alone? These are the problems now bedeviling many disciplines in the counseling field. In the volume under review the agency gives answers to these and other questions.

Social work has been and is outstanding in its contributions in the

field of family counseling. Most other groups have limited their counseling to one particular area of counseling, such as vocational guidance, child guidance, and marriage counseling. The advantages of treating all the people in a family are obvious in the light of our present realization of the totality of a human being, the importance of the effect on him of his relationships.

This volume, which is a collection of papers written by staff members of the Family Service Society, presents this agency's principles and practices and methods of diagnosis and treatment, the rôle of the psychiatrist consultant, the principles and practice used in the supervision of workers, in-service training for workers, a description of the research program recently introduced, and the agency's concept of family-life education.

The agency defines the function of family counseling as "helping members of a family who have a problem in their relationship with each other or those who need to work out an adjustment to a specific reality that is creating a conflict for them."

Their supervision of their workers, a process that is highly commendable and that is not used by many other disciplines is, as stated, essential to make the worker aware of personal feelings and needs, thus enabling him "to guard against their interfering in his relationship to clients and yet be sufficiently responsive to further experience, to development on the job, and to supervision, to be capable of change, and at times even of resolution of the problem."

In-service training is another device used by the agency to safeguard and continue improvement of the quality of the counseling service.

The agency has worked out to their own satisfaction and that of their consulting psychiatrists a method of collaboration to aid in the diagnosis and understanding of the psychodynamics involved in helping a client. But though they have, as they state, established sound methods, they recognize that they "have yet to establish universal criteria for case-work helpfulness." To that end various research projects have been devised.

This helping process that the family agency has described for family counseling resembles very closely what can be termed psychoanalytically oriented psychotherapy. This reviewer is looking forward to the complete maturity of the agency, when it will call its methods of treatment what they truly are—excellently formulated forms of psychotherapy.

LENA LEVINE

Marriage Counseling Service,
Mothers' Health Center,
Brooklyn, New York.

THE SOCIAL AND BIOLOGICAL CHALLENGE OF OUR AGING POPULATION. (Proceedings of the Eastern States Health Education Conference, 1949.) New York: Columbia University Press, 1950. 183 p.

This unusually interesting and informative volume quickly and thoroughly orients the reader to the diverse problems presented by our aging population. The familiarity of the contributors with their respective fields induces an easy, but penetrating exposition of the known facts and their correlations, provoking fascinating and optimistic speculation regarding future achievements.

A foreword by Dr. B. P. Watson, President of the New York Academy of Medicine, who sponsored the Eastern States Health Education Conference, indicates its purpose and scope. Dr. Iago Galdston refers in the introduction to the need for multidimensional comprehension to meet the challenge of this human problem. An orientation to the specific problems embraced is furnished by Dr. Norton S. Brown.

The subject matter of these Proceedings is replete with pertinent specific information and conceptions, of which only a few can be mentioned in a brief review. The organizational developments in gerontology since 1939 are discussed by Dr. V. Korenchevsky, of Oxford. This eminent investigator and active influence in gerontological and geriatric progress presents a succinct historical and contemporary working background of specific needs and difficulties in research. He describes research facilities now available internationally, as well as those still required for investigations, which may result in preventing or retarding the pathological features of aging so important to all people. He advocates coöperative research and the establishment of a gerontological research foundation, similar in type to the Rockefeller, Carnegie, or Nobel foundations, with generous financial support such as that granted by Lord Nuffield in Great Britain.

Many other questions of aging are raised, and answers are given or attempted. Dr. Jean Oliver, commenting on the structural aspects of aging, considers evidence on how much of senescence is normal and how much is disease. He concludes that undue avoidable stresses are often the cause of final disintegration.

The complex factors in the existence and nature of our aging population are clearly presented by Dr. Clyde V. Kiser and Dr. Vasilios G. Valaoras in separate discussions. It is shown that a lowered mortality rate, a decline in immigration, and a decline in fertility, especially the latter, account largely for the increasing relative numbers of older people. Dr. Frederick J. Tisdall deals with

controllable factors in aging, such as proper diet, and suggests that the study of aging should start with the obstetrician and the pediatrician. Dr. David Seegal outlines the progress that has been made in controlling chronic disease, with enhanced prospects for the future. Dr. Edward B. Allen discusses psychological factors that have a bearing on physiological and even physical changes. He stresses the mental-hygiene aspects of aging and urges "retiring not from, but to some activity."

Sociological problems receive proper attention. *The Retirement Myth* is a critical survey of this problem by Julius Hochman, who feels that older people in our culture prefer work to retirement. Dr. Kingsley Davis and J. W. Combs, Jr. find it desirable to keep older people productive and note that in the future chronologically older people may be organically younger than now. Special problems arise in our culture because of the orientation toward youth. Eduard C. Lindeman, L.L.D. makes further positive suggestions for the reorientations required for a more effective program for older people.

The reading of this volume is heartily recommended.

HOLLIS E. CLOW.

New York Hospital-Westchester Division,
White Plains, New York.

THE COLLECTED PAPERS OF ADOLF MEYER. Edited by Eunice E. Winters. Volume I. *Neurology.* Baltimore: The Johns Hopkins Press, 1950. 693 p.

Friends, pupils, and admirers of Dr. Meyer and his work will heartily welcome his collected papers, which will appear in four volumes. The first volume contains his neuroanatomical and neuropathological papers, and is suitably introduced with a sketch of Meyer's contributions to neurology by Dr. Louis Hausman, his pupil and collaborator. For the specialist the volume provides a valuable reference book of Meyer's morphological studies, and shows his lasting influence in the neurological field. Those, on the other hand, who know Meyer primarily as a great psychiatrist will find the volume equally stimulating, since many of the articles written in the formative years of Meyer's life are quite unmistakably forerunners of his later psychiatric teachings. Any one interested in the development of the powerful and outstanding mind of Dr. Meyer will find the book indispensable.

In addition to his anatomical papers, almost all of which were written in the first two decades of Meyer's scientific career, the volume contains numerous reviews of neurological books which offer significant

side glances at Meyer's personality and reveal his unusually keen insight into scientific problems of the day.

Two articles written late in his life will be of particular interest to the historian of medicine. The first of these, written in honor of Dr. B. Sachs, contains Meyer's views on the development and tasks of neurology and psychiatry; the other, in honor of Dr. J. C. Herrick, reflects the scientific atmosphere in the United States as Meyer perceived it at the turn of the century and contains a considerable amount of autobiographical data.

The difficult editorial task has been accomplished most skillfully by Miss E. E. Winters. A table of contents, a list of illustrations, and a subject and author's index permit an easy orientation in the volume. The illustrations (partly in color) are reproduced beautifully and for the most part with the clarity of the originals.

JERZY E. ROSE

The Johns Hopkins University,
School of Medicine, Baltimore, Maryland

NOTES AND COMMENTS

The First Annual Meeting of The National Association for Mental Health

The First Annual Meeting of The National Association for Mental Health was held at the Conrad Hilton Hotel in Chicago, November 29–December 1, 1951. Approximately 250 persons attended from 30 states. Most of those registered were active workers in mental-health organizations at the national, state, and community level—executives, officers, board members, and committee members.

The subject matter of this year's sessions was confined primarily to the "how" of doing the job—how to find, build, and use leadership; how to proceed with fund-raising plans and Mental Health Week plans in 1952; how to conduct a mental-health-education program; and how to develop social action, volunteer, and other forms of service projects. The pattern was established to be consistent with the Association's recognized primary responsibility for the development of a well-integrated network of mental-health organizations reaching into every corner of the country. The conference was conceived in a sense as a gathering together of the members of a team, in order to strengthen the feelings of unity and increase integration within the voluntary mental-health movement.

Several things stand out as high lights in the conference. Especially outstanding was the spirited enthusiasm of the participants for the cause of mental health and the exciting accomplishments that many groups were prepared to report. Equally important was the feeling that at last the workers in the movement had come together to think and plan about their common problems.

The conference opened with a luncheon for the delegates, presided over by Dr. George S. Stevenson, medical director of the Association, and addressed briefly by Mr. Oren Root, the president. The principal talk was given by Dr. Andre Répond, past president of the World Federation for Mental Health. His talk will appear in a later issue of Mental Hygiene.

There was also a public dinner in connection with the conference which was held in the grand ballroom of the Conrad Hilton Hotel and attended by more than 500 persons. This meeting was opened by Mr. Ronald Boardman, President of the Illinois Society for Mental Hygiene and was addressed by Governor Adlai Stevenson of the State of Illinois.[1]

The principal address, entitled *Men, Machines, and Mental Health,*

[1] For this address, see pages 1–5 of this issue of Mental Hygiene.

was presented by Dr. William C. Menninger. His address also will appear in a later issue of this magazine. As a unique part of the program, the new Theatre Wing Play on mental health ... *And You Never Know* was put on by the Junior League of Chicago.

The legal reason for the annual meeting is the requirement in the by-laws that there shall be such a meeting of the members to receive the annual report and to elect members to the board of directors. The meeting was held as required. The printed report of the board was received and 45 directors were elected, including 15 new directors—3 from each of the 5 regions of the country into which the organization membership of the Association is divided. The new board of directors will be found listed on the inside back cover of MENTAL HYGIENE. After the annual meeting of the members, the annual meeting of the board of directors was conducted and necessary steps were taken for the launching of the activities of the new year, looking forward to even greater progress than that experienced during the organization's successful first year of operations.

WALTER D. FULLER TO HEAD COMMERCE AND INDUSTRY COMMITTEE OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

Walter D. Fuller, Chairman of the Board of The Curtis Publishing Company, Philadelphia, has accepted the chairmanship of the Commerce and Industry Committee of The National Association for Mental Health. This committee, which includes some of the nation's outstanding business leaders from every region of the country, has been established to consider industry's approach to mental-health problems in several ways. Efforts will be directed toward (1) helping to set up pilot research projects on industry's mental-health problems; (2) helping industry to make more effective utilization of community psychiatric resources for their personnel in need of such care; (3) serving as a clearing house for the exchange of information as to how firms are handling their human-relations problems; and (4) making available to industry the knowledge gained from research in human behavior.

"Industry's stake in mental health is a tremendous one," stated Mr. Fuller, in accepting the chairmanship of the committee. "Mental and emotional illness costs American employees and employers billions of dollars annually in lost production and hence substantially reduces our nation's tax revenues. Emotional disorders, which can be minimized with available methods, are known to contribute substantially to high accident rates, absenteeism, substandard production, and a wide variety of personnel problems. The improperly adjusted worker in industry is only part of the much greater mental-health problem that all of us face."

It is the plan of The National Association for Mental Health to invite outstanding leaders in other fields, such as labor, education, religion, social welfare, and medicine, to participate in similar special committees, in an effort to rally the best thinking of the country toward strengthening the mental-health resources of the community.

Thirtieth Annual Convention of the National Society for Crippled Children and Adults

Hundreds of delegates from all parts of the United States attended the Thirtieth Annual Convention of the National Society for Crippled Children and Adults, the Easter Seal Society, which was held at the Palmer House in Chicago October 3–5. Through speeches, panel discussions, instructional institutes and seminars, representatives of the professions, business, industry, and lay group learned that (1) great advances continue in rehabilitating the handicapped; (2) the crippled must be trained and recognized as invaluable, competent workers necessary in the national defense effort; (3) the volunteer plays an increasingly important rôle in making services to the handicapped possible.

Research toward the prevention of crippling diseases and accidents was advocated as the first step in combating the mounting toll of handicapped persons in the United States, in the opening address by Dr. Andrew C. Ivy, Vice President of the University of Illinois. "Unless crippling childhood diseases are reduced," Dr. Ivy said, "by 1980 we will see 20 per cent of our people working to support the other 80 per cent." He also urged the extension of medical research to the prevention of accidents, especially in the home, which, he said, "must be made a less hazardous place in which to live."

To-day's handicapped population was characterized as a "human uranium supply" by Dr. Theodore G. Klumpp, president of the New York chemical firm of Winthrop-Stearns and chairman of the President's newly formed Task Force to mobilize the handicapped for defense employment. Dr. Klumpp said that the potential supply of women workers is not as great as it was during World War II and so the nation must resort to handicapped workers in the defense effort.

In line with the convention's theme of "Voluntary Effort—National Strength," Mary E. Switzer, Director of the U. S. Office of Vocational Rehabilitation, stressed the urgent need for voluntary agencies to work coöperatively with public agencies in rehabilitating the crippled.

Her ideas were supported by Henry Viscardi, Jr., Executive Director of the "Just One Break for the Disabled" Committee, New York University-Bellevue Hospital Center, who said that the crippled must be given a chance to show what they can do. "Absence of disease

doesn't mean physical fitness from an industrial standpoint," Mr. Viscardi said. Handicapped workers have been found to be just as competent as the able-bodied, in some cases more competent.

Proof of his statement was given in a clinical demonstration by Dr. George G. Deaver, past president of the American Academy for Cerebral Palsy and Medical Director of the Lenox Hill Hospital Pre-School Cerebral Palsy Center, New York. Dr. Deaver directed an actual demonstration of crippled individuals at work, a sample of those who have become successful workers despite severe handicaps.

Four other distinguished handicapped persons presented their viewpoints on life in a panel discussion, "As We See It"—Glenn Cunningham, former Olympic track star; W. Ernest DeCoursey, advertising executive; James F. Palmer, professor of journalism; and Lidia Hernandez, social-service consultant to the ministry of health in Argentina. All agreed that "you're never really crippled till your mind is in a splint."

The importance of the volunteer was again stressed by Margaret Hickey, editor of the public-affairs department of the *Ladies Home Journal,* who was the featured speaker on the Cerebral Palsy Day program, October 5. She said that voluntary agencies are basically essential for providing leadership in the promotion of research and services in the field of social and health problems. "Too many people," she said, "say, 'Let the government do it,' when it is coöperation between private and governmental agencies that we need."

Expansion in the cerebral-palsy program of Easter Seal agencies was outlined by Dr. Wallace A. Goates, director of the University of Utah's speech and hearing clinic. He said that Easter Seal funds now support 367 treatment services for the cerebral palsied compared to the 16 that were in operation five years ago.

Latest techniques and methods in treatment of the cerebral palsied were discussed and demonstrated in a series of instructional institutes for parents and volunteers and in seminars for professional workers in the fields of medicine, therapy, and education. Work in other areas for the handicapped was depicted in 73 exhibits displayed by various agencies.

Davis E. Geiger, of Ashland, Kentucky, succeeded Gerard M. Ungaro as president of the national society. William T. Sanger, President of the Medical College of Virginia, Richmond, was chosen president-elect.

American Board of Psychiatry and Neurology Elections

Officers for 1952 were elected by the American Board of Psychiatry and Neurology at a meeting in New York City in December, at which time 275 candidates for certification in psychiatry and neurology were

examined. Dr. Francis J. Braceland, Psychiatrist-in-Chief of the Institute of Living in Hartford, Connecticut, is the new president of the board. The vice president is Dr. Bernard J. Alpers, professor of neurology at Jefferson Medical College, Philadelphia; and the secretary-treasurer is Dr. David A. Boyd, professor of psychiatry in the Graduate School of the University of Minnesota, and consultant to the Mayo Clinic. The next meeting of the board will be held in Chicago in June, 1952, at which time examinations will be given at the Neuropsychiatric Institute of the University of Illinois.

Annual Dinner of the Pennsylvania Psychiatric Society

At the Thirteenth Annual Dinner Meeting of the Pennsylvania Psychiatric Society, which took place at the University Club, in Pittsburgh, September 20, 1951, Henry W. Brosin, M.D., spoke on "Current Activities at the Western Psychiatric Institute and Clinics."

The following officers were elected to serve for the year 1951–1952: president, Robert H. Israel, M.D., of Warren; president-elect, Philip Q. Roche, M.D., of Philadelphia; and secretary-treasurer, M. Roydon C. Astley, M.D., also of Philadelphia.

Annual Reading Clinic at Temple University

The Ninth Annual Reading Institute at Temple University has been announced for the week of January 28 to February 1, 1952. The theme is "Prevention and Correction of Reading Difficulties."

During this institute, the following sequence of topics will be discussed and demonstrated: (1) planning a reading program; (2) reading in a language arts setting; (3) evaluating achievement, progress, and capacity; (4) analysis of reading difficulties, (5) common difficulties in reading; (6) symptoms and causes of reading disabilities; (7) types of reading problems; (8) phonetics and word recognition; (9) semantic analysis and comprehension development; (10) reading skills and techniques; (11) directed reading and reading readiness activities; (12) differentiated instruction; (13) materials for developmental and corrective reading; (14) organization of corrective and remedial classes; and (15) speed reading.

In addition to the Temple University Reading Clinic staff and their colleagues, distinguished specialists in reading will take part in the clinic. Members of the institute staff are selected on the basis of their professional contributions to developmental, corrective, or remedial reading.

Laboratory practice under competent supervision will be provided in half-day sessions. Two sessions are scheduled for the construction of informal reading inventories and teaching plans for a directed

reading activity. Other sessions, providing practice with children, will deal with the following activities: (1) estimation of reading and hearing comprehension levels; (2) the identification of different types of reading disabilities; (3) the use of corrective and remedial techniques; (4) the evaluation of reading readiness; (5) speed reading; and (6) the detection of visual problems. All laboratory practice is differentiated for elementary, secondary, and college teachers.

Procedures and techniques will be demonstrated by the institute staff. These demonstrations will include individual and group reading inventories, directed reading-readiness activities, directed reading activities, and corrective and remedial techniques.

During the institute, five divisions of the reading clinic will conduct regular staff meetings on specific problems. These divisions include: Reading Analysis, Reading Clinic Laboratory School, College Reading Service, Adult Reading Service, and Speed Reading.

Reading programs in public schools and colleges will be presented by delegates and evaluated by a selected staff during three half-day sessions.

Conference hours, with members of the institute staff, are scheduled in the official printed program.

Enrollment is limited by advance registration. For a copy of the program and other information regarding the institute, write Emmett Albert Betts, Director, The Reading Clinic, Temple University, Broad and Montgomery Avenue, Philadelphia 22, Penna.

1951 Meeting of the Central Neuropsychiatric Association

The Central Neuropsychiatric Association met in St. Paul and Minneapolis, October 19 and 20. Many members visited Rochester, Minnesota, on the day preceding the meeting. The Minnesota Society of Neurology and Psychiatry were hosts and the scientific program was prepared under their auspices.

The next meeting will take place in Nashville, Tennessee, during October, 1952. The exact date has not yet been selected.

Massachusetts Has New Commissioner of Mental Health

Announcement has recently been made of the appointment, by Governor Paul A. Dever, of a new commissioner of mental health to fill the position left vacant by the resignation of Dr. Clifton T. Perkins over a year ago. The new commissioner is Dr. Jack R. Ewalt, of Houston, Texas, Dean of the Post-Graduate School of Medicine at the University of Texas.

Dr. Ewalt, who was born in Kansas in 1910, is a graduate of the University of Colorado and the Colorado School of Medicine. From

1937 to 1938, he served at the Fitzsimmons Hospital (U. S. Army) as contract physician and neuropsychiatrist. He was assistant professor of psychiatry at the University of Colorado until 1941, and associate professor of neuropsychiatry at the University of Texas until 1944, when he became a full professor. He was also director of the department of electroencephalography from 1944 to 1950, and director of the Psychopathic Hospital of the University of Texas and administrator of the medical branch hospitals of the university from 1945 to 1950, when he became dean of the Post-Graduate School of Medicine.

He is the author of many publications and was co-author with Dr. Strecker and Dr. Ebaugh on the seventh edition of their book, *Practical Clinical Psychiatry*, published in 1951.

A Continuation Course in Clinical Neurology

A continuation course in clinical neurology, covering the period from January 28 to February 9, has been announced by the Department of Continuation Medical Education of the University of Minnesota Medical School. Among the participants will be Dr. Harold G. Wolff, professor of medicine and associate professor of psychiatry, Cornell University Medical College, New York City, who is to give the annual J. B. Johnston Lecture on January 30.

Other visiting faculty members for the course include Dr. Benjamin Boshes, associate professor of neurology, Northwestern University Medical School, Evanston, Illinois; Dr. H. Houston Merritt, professor of neurology, Columbia University, and Director of the Service of Neurology, Neurological Institute, Presbyterian Hospital, New York City; and Dr. Henry G. Schwartz, professor of neurosurgery, Washington University School of Medicine, St. Louis, Missouri.

New Jersey Graduates Eighth Class of Psychiatric Technicians

Commencement exercises for the eighth class of psychiatric technicians to be graduated in New Jersey were held in the auditorium of the New Jersey State Hospital at Trenton on the night of December 5. The exercises marked the completion of a year of intensive training in one of the three New Jersey state hospitals or the Skillman State Village for Epileptics. There were 19 in the graduating class. While this was one of the smallest classes ever to be graduated, it was indicative of the progress that is being made in the training program whereby persons of marginal ability or performance are screened out in the early months of the course instead of being carried along and graduated, as in earlier years.

In spite of bad weather, the exercises were attended by an audience

of some 250 people—New Jersey officials, members of the various hospital staffs, and families and friends of the graduates. Dr. Harold Magee, Superintendent of the Trenton Hospital, served as master of ceremonies. The program included remarks from Commissioner Sandford Bates; two vocal selections by Miss Jane Robertson, of Westminster Choir College; and a talk by Miss Lucy Freeman, of the New York *Times*. The presentation of certificates was made by Miss Freeman and Raymond Male, Director of Personnel of the New Jersey State Department of Institutions and Agencies. The exercises were followed by a social period during which refreshments were served.

A Grant of $250,000 for Western Psychiatric Institute and Hospital

A $250,000 gift from the A. W. Mellon Educational and Charitable Trust has brought the University of Pittsburgh one step nearer the financial goal needed to carry on its program in psychiatry and mental health. The grant, announced by Dr. R. H. Fitzgerald, chancellor, provides $50,000 a year for a five-year period.

This is the fourth grant received by the university from local foundations to aid the five-year program at the Western Psychiatric Institute and Clinic. Previous grants for the five-year period include: (1) a $250,000 grant from the Maurice and Laura Falk Foundation, to be paid at the rate of $50,000 per year; (2) a $75,000 grant from the Sarah Mellon Scaife Foundation, to be paid at the rate of $15,000 per year; (3) a $25,000 grant from the Howard Heinz Endowment, to be paid at the rate of $5,000 per year.

The annual budget for the teaching, research, and clinical program of the Western Psychiatric Institute and Clinic has been set at $1,750,000. Of this amount it is expected that $1,600,000 will be appropriated by the state legislature.

The program is headed by three specialists: Dr. Henry W. Brosin, Medical Director of the Western Psychiatric Institute and Clinic; Dr. I. Arthur Mirsky, head of the research division; and Dr. Benjamin Spock, professor of child development. Before coming to Pittsburgh, Dr. Brosin was professor of psychiatry and head of the division of psychiatry at the University of Chicago Medical School; Dr. Benjamin Spock, authority on child development and preventive mental hygiene, was with the Mayo Clinic and the University of Minnesota; and Dr. Mirsky was associate professor of experimental medicine in psychiatry at the University of Cincinnati School of Medicine and Director of the May Institute at Cincinnati.

The Western Psychiatric Institute and Clinic was built by the commonwealth of Pennsylvania in 1942 as a teaching and research institute, on land furnished by the University of Pittsburgh adjacent

to the hospitals in the Medical Center. It was operated by the Department of Mental Hygiene of the Pennsylvania Department of Welfare as a part of the mental-hospital system of the state until September, 1949. Then the university assumed responsibility for carrying out the purposes for which the institute was originally built.

"... And You Never Know"

... *And You Never Know,* a one-act play by Nora Stirling, is the latest in a series of dramas produced by the American Theatre Wing Community Plays in collaboration with The National Association for Mental Health and local mental-health groups, for the purpose of helping parents get along with one another and meet the emotional needs of their children. Three earlier dramatic sketches produced in this same manner and released under the title, *The Temperate Zone,* have had numerous performances throughout the country.

We meet the play's three characters during a Saturday morning crisis, with a mother accusing a daughter of jealousy toward her younger sister and reproaching her husband of "detachment." By good humor and understanding, the husband sets the day to rights. In the fray, the three gain some insight into their individual emotional problems.

An integral feature of these dramatic sketches is the open discussion period that should follow the final curtain. The emotional effect of drama is deliberately used as an educational tool. As the dramas unfold, parents share the emotions, the experiences, and the problems of the characters of the plays. For many parents the discussion becomes an adventure in self-discovery. They find themselves sharing thoughts with other parents and expressing ideas that they scarcely knew they had. The play runs approximately 35 minutes.

The National Association for Mental Health will publish ... *And You Never Know* in February, 1952. At that time, the play will be ready for amateur production throughout the country, with the exception of metropolitan New York. A production packet, consisting of four copies of the script, with suggestions for the discussion period, will be available at a price yet to be determined (approximately $3.50 to $4.00).

Jewish Child Care Association and Hillside Hospital to Conduct Residency Training Program

Plans have been worked out for a new residency psychiatric training program to be conducted jointly by the Jewish Child Care Association of New York and Hillside Hospital. The move, which opens

an important channel for teamwork between psychiatrists and social workers in the development of healthy personalities in children, has been authorized and certified by the American Medical Association's Council on Medical Education and Hospitals and the American Board of Psychiatry and Neurology.

Under the terms of the joint plan, the Jewish Child Care Association's Pleasantville Cottage School will serve as the training center during the third year of the formal three-year residency teaching program of Hillside Hospital for doctors who wish to specialize in psychiatry. Plans call for the inauguration of the program by January, 1952.

The Jewish Child Care Association of New York, one of the largest voluntary child-serving agencies in the country for children from temporarily disrupted homes, offers a social case-work program which, when necessary, is supplemented by psychiatric service. While the agency's social case-work program is adequate for most of the children in its care, from 25 per cent to 30 per cent require some type of psychiatric assistance, but only 15 per cent need intensive help. The psychiatric service is currently administered by eight staff psychiatrists, 20 panel psychiatrists, and three consultants.

Hillside Hospital is one of the few voluntary non-profit and non-sectarian psychiatric institutions in the country that accepts suitable cases for treatment regardless of the patients' ability to pay. It has been steadily expanding its service and accepts for treatment patients suffering from mild and acute mental disorders in which the outlook is good for ready response to psychotherapy. Over 80 per cent of the patients discharged from Hillside Hospital in recent years, it is reported, recovered or showed definite signs of improvement.

Dr. Clarence P. Oberndorf, Director of Psychiatry of the Jewish Child Care Association, and Dr. Joseph S. A. Miller, Medical Director of Hillside Hospital, in their joint announcement, stated that both the association and the hospital stand to derive important benefits from the new program, "which represents the culmination of a well-established relationship under which psychiatrists from the hospital have been serving on the staff and panel for psychiatrists of the child-care agency."

They pointed out that "when the new program is launched, the Jewish Child Care Association will have additional psychiatric services for the children and a group of psychiatrists, who may possibly specialize in child psychiatry, will be trained to be more fully aware of the problems and needs of children placed in care away from their own homes."

Edgewood Sanitarium Holds Second Annual Series of Lectures

On September 20 and 21, the second annual series of the Fowler Lectures was held at Edgewood Sanitarium Foundation, Orangeburg, S. C. The series took the form of a two-day session on alcoholism and drug addiction, with three additional lectures devoted to the subject "Religion and Psychiatry," a timely topic that is fast gaining the attention of the American public.

Included on the program of the symposium were such nationally known authorities as Dr. Harry Isbell, Director of Drug Research, Public Health Service, Lexington, Kentucky; Dr. Leon Greenberg, scientist, author, and inventor of the alcometer of Yale University; Dr. Francis McPeak, author, minister, and industrial counselor, Chicago, Illinois; Dr. Raymond McCarthy, author and director of educational activities of the Connecticut Commission on Alcoholism; Dr. Aaron Rutledge, minister, marriage counselor, and professor at Furman University; and others.

The lectures featured morning, afternoon, and evening addresses, discussion periods, and films. The various sessions were attended not only by physicians, social workers, nurses, psychologists, and welfare workers from North Carolina, South Carolina, and Georgia, but also by educators, clergymen, legislators, judges, youth-group leaders, and representatives of Parent-Teacher Associations, mental-hygiene groups, police forces, and the public in general.

No fees were charged for any of the lectures at Edgewood. In an effort to carry out the Ten-Point Program of the South Carolina Medical Association, the Edgewood Sanitarium Foundation arranges these educational symposia annually as one feature of an extensive educational program.

Scouting With the Handicapped

The Boy Scouts of America now has registered over 300 Scout units in various agencies made up of mentally handicapped and physically handicapped boys. The value of this program of group activities is highly extolled by directors and staff members of special schools and hospitals that use the Scout Program.

A list of these institutions can be secured by writing to the School Service, Boy Scouts of America, 2 Park Avenue, New York 16. Further information can be secured by writing to the individual schools that use the program.

The Sigmund Freud Archives

The Sigmund Freud Archives was incorporated in the state of New York on February 14, 1951. It was organized by a group of

internationally eminent psychoanalysts. Its aim, as stated in the charter, is "to discover, assemble, collect, and preserve manuscripts, publications, and other documents and information relating to the biography of the late Sigmund Freud, and to his medical, psychoanalytic, and other scientific activities." This is the first attempt to obtain and preserve for posterity a complete compilation of Freud's published and unpublished writings. Under the agreement with the Library of Congress, which will serve as curator of the collection, confidential material will be restricted as per the request of the donor.

The initial projects of the archives include collecting all letters to and from Freud; establishing a complete and reliable bibliography of his writings; interviewing all persons who knew Freud personally—regardless of how well they knew him or in what function, whether as friend, as brief acquaintance, or as his patient.

Any one who is in possession of letters to or from Freud, or who knows of persons who have such letters, as well as all those who knew Freud personally, are urged to communicate with the Sigmund Freud Archives, 575 Madison Avenue, New York 22.

News of Mental-Hygiene Societies

During the past two years, "News of Mental Hygiene Societies" has been compiled and reported in detail in the "Notes and Comments" department of MENTAL HYGIENE. In November, 1951, a questionnaire was submitted to all state and local mental-health organizations requesting their suggestions as to how this section might be improved from the point of view of its assistance to them in organization and program planning. From their answers, as well as from comments received at the annual meeting of the National Association for Mental Health, in December, we find that the mental-health associations would prefer another type of national medium for an exchange of news, including also news of activities at the national level. Some mental-health organizations publish their own newsletters, describing their projects in more detail than is possible in MENTAL HYGIENE, and these can be obtained directly from the associations.

At the present time, therefore, the national staff are working on the preparation of another method for the dissemination of helpful information. In addition to state and local mental-health organizations, others interested in obtaining this material may write to the Division of Community Organization, The National Association for Mental Health, requesting inclusion on the mailing list.

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Compiled by

EVA R. HAWKINS

New York City

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